

# **October 1, 2011 Submission--DRAFT**

**Department of Social Services**

**Fiscal Year 2013**

**Budget Request**

**MO HealthNet Division**

**Brian Kinkade, Interim Director**

Page No.	Dept Rank	Decision Item Name
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2013 Department Request				
FTE	GR	FF	OF	Total

**MO HealthNet Administration**

50	1	Core	227.11	3,473,535	8,284,283	2,227,897	13,985,715
		<i>Total</i>	227.11	3,473,535	8,284,283	2,227,897	13,985,715

**Clinical Services Program Management**

62	1	Core	0.00	483,913	12,215,288	5,085,805	17,785,006
34	14	Sustain MHD Technology Infrastructure	0.00	2,187,500	0	0	2,187,500
		<i>Total</i>	0.00	2,671,413	12,215,288	5,085,805	19,972,506

**Women & Minority Health Care Outreach**

71	1	Core	0.00	546,125	568,625	0	1,114,750
		<i>Total</i>	0.00	546,125	568,625	0	1,114,750

**TPL Contracts**

79	1	Core	0.00	0	1,500,000	1,500,000	3,000,000
		<i>Total</i>	0.00	0	1,500,000	1,500,000	3,000,000

**Information Systems**

89	1	Core	0.00	4,838,940	32,880,170	0	37,719,110
34	14	Sustain MHD Technology Infrastructure	0.00	2,500,000	22,500,000	0	25,000,000
		<i>Total</i>	0.00	7,338,940	55,380,170	0	62,719,110

**Electronic Health Records Incentives**

99	1	Core	0.00	0	60,000,000	0	60,000,000
105	17	Electronic Health Records Incentives	0.00	0	38,362,500	0	38,362,500
		<i>Total</i>	0.00	0	98,362,500	0	98,362,500

**Pharmacy**

112	1	Core	0.00	142,230,782	613,983,324	215,136,932	971,351,038
1	6	Caseload Growth	0.00	4,422,101	7,458,880	0	11,880,981
25	10	Pharmacy PMPM	0.00	13,548,597	22,852,792	0	36,401,389
		<i>Total</i>	0.00	160,201,480	644,294,996	215,136,932	1,019,633,408

**Pharmacy - Medicare Part D Clawback**

125	1	Core	0.00	180,575,272	1	0	180,575,273
131	13	Clawback Increase	0.00	20,507,743	0	0	20,507,743
		<i>Total</i>	0.00	201,083,015	1	0	201,083,016

**Missouri Rx Plan**

137	1	Core	0.00	0	0	19,602,166	19,602,166
		<i>Total</i>	0.00	0	0	19,602,166	19,602,166

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2013 Department Request				
FTE	GR	FF	OF	Total

**Pharmacy FRA**

146	1	Core	0.00	0	0	90,308,926	90,308,926
		<i>Total</i>	0.00	0	0	90,308,926	90,308,926

**Physician Related**

153	1	Core	0.00	207,623,449	394,012,708	4,194,685	605,830,842
1	6	Caseload Growth	0.00	2,480,771	4,184,386	0	6,665,157
43	16	Medicaid Primary Care Rate Increase	0.00	0	35,394,115	0	35,394,115
		<i>Total</i>	0.00	210,104,220	433,591,209	4,194,685	647,890,114

**Dental**

167	1	Core	0.00	6,486,786	12,907,120	919,935	20,313,841
1	6	Caseload Growth	0.00	60,914	102,746	0	163,660
		<i>Total</i>	0.00	6,547,700	13,009,866	919,935	20,477,501

**Premium Payments**

177	1	Core	0.00	73,327,895	133,146,476	0	206,474,371
1	6	Caseload Growth	0.00	670,393	1,130,770	0	1,801,163
186	11	Medicare Premium Increase	0.00	3,586,563	6,356,619	0	9,943,182
		<i>Total</i>	0.00	77,584,851	140,633,865	0	218,218,716

**Nursing Facilities**

193	1	Core	0.00	133,598,846	354,607,642	70,262,188	558,468,676
		<i>Total</i>	0.00	133,598,846	354,607,642	70,262,188	558,468,676

**Home Health**

204	1	Core	0.00	2,531,358	4,678,833	159,305	7,369,496
1	6	Caseload Growth	0.00	44,588	75,208	0	119,796
		<i>Total</i>	0.00	2,575,946	4,754,041	159,305	7,489,292

**PACE**

212	1	Core	0.00	1,552,734	3,520,959	0	5,073,693
		<i>Total</i>	0.00	1,552,734	3,520,959	0	5,073,693

**Rehab & Specialty Services**

222	1	Core	0.00	81,647,861	163,405,313	12,582,499	257,635,673
1	6	Caseload Growth	0.00	676,761	1,141,512	0	1,818,273
233	12	Hospice Rate Increase	0.00	176,688	298,003	0	474,691
		<i>Total</i>	0.00	82,501,310	164,844,828	12,582,499	259,928,637

Page No.	Dept Rank	Decision Item Name
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2013 Department Request				
FTE	GR	FF	OF	Total

**NEMT**

239	1	Core	0.00	10,923,967	25,919,527	0	36,843,494
1	6	Caseload Growth	0.00	95,685	161,394	0	257,079
		<i>Total</i>	0.00	11,019,652	26,080,921	0	37,100,573

**Managed Care**

249	1	Core	0.00	303,877,638	731,080,298	113,308,176	1,148,266,112
1	6	Caseload Growth	0.00	2,362,853	3,985,489	0	6,348,342
16	9	Managed Care Actuarial Increase	0.00	21,964,228	37,047,670	0	59,011,898
43	16	Medicaid Primary Care Rate Increase	0.00	0	15,335,897	0	15,335,897
		<i>Total</i>	0.00	328,204,719	787,449,354	113,308,176	1,228,962,249

**Hospital Care**

261	1	Core	0.00	24,567,406	552,654,659	272,353,739	849,575,804
1	6	Caseload Growth	0.00	6,686,121	11,277,665	0	17,963,786
		<i>Total</i>	0.00	31,253,527	563,932,324	272,353,739	867,539,590

**Physician Payments for Safety Net**

275	1	Core	0.00	0	8,000,000	0	8,000,000
		<i>Total</i>	0.00	0	8,000,000	0	8,000,000

**FQHC Distribution**

282	1	Core	0.00	4,020,000	9,000,000	0	13,020,000
		<i>Total</i>	0.00	4,020,000	9,000,000	0	13,020,000

**IGT Health Care Home**

291	1	Core	0.00	0	9,000,000	1,000,000	10,000,000
		<i>Total</i>	0.00	0	9,000,000	1,000,000	10,000,000

**Federal Reimbursement Allowance**

298	1	Core	0.00	0	0	878,929,394	878,929,394
305	20	Increase Authority	0.00	0	0	67,500,000	67,500,000
		<i>Total</i>	0.00	0	0	946,429,394	946,429,394

**IGT Safety Net Hospitals**

311	1	Core	0.00	0	129,505,748	70,348,801	199,854,549
		<i>Total</i>	0.00	0	129,505,748	70,348,801	199,854,549

**IGT DMH Medicaid Programs**

318	1	Core	0.00	0	112,898,554	65,731,662	178,630,216
		<i>Total</i>	0.00	0	112,898,554	65,731,662	178,630,216



Page No.	Dept Rank	Decision Item Name
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2013 Department Request				
FTE	GR	FF	OF	Total

**Women's Health Services**

325	1	Core	0.00	1,845,337	9,027,051	216,790	11,089,178
25	10	Pharmacy PMPM	0.00	16,254	146,287	0	162,541
		<i>Total</i>	0.00	1,861,591	9,173,338	216,790	11,251,719

**CHIP**

335	1	Core	0.00	27,758,255	132,983,811	16,991,480	177,733,546
1	6	Caseload Growth	0.00	305,996	868,652	0	1,174,648
16	9	Managed Care Actuarial Increase	0.00	1,243,058	3,528,758	0	4,771,816
25	10	Pharmacy PMPM	0.00	443,581	1,259,227	0	1,702,808
		<i>Total</i>	0.00	29,750,890	138,640,448	16,991,480	185,382,818

**Nursing Facility FRA**

345	1	Core	0.00	0	0	235,091,756	235,091,756
353	21	Increase Authority	0.00	0	0	41,735,962	41,735,962
		<i>Total</i>	0.00	0	0	276,827,718	276,827,718

**School District Medicaid Claiming**

361	1	Core	0.00	69,954	54,653,770	0	54,723,724
		<i>Total</i>	0.00	69,954	54,653,770	0	54,723,724

**State Medical**

370	1	Core	0.00	31,977,873	0	1,813,765	33,791,638
25		Pharmacy PMPM	0.00	433,442	0	0	433,442
		<i>Total</i>	0.00	32,411,315	0	1,813,765	34,225,080

**MO HealthNet Supplemental Pool**

378	1	Core	0.00	0	24,107,486	11,590,599	35,698,085
		<i>Total</i>	0.00	0	24,107,486	11,590,599	35,698,085

*Total MO HealthNet Core*

227.11	1,243,957,926	3,594,541,646	2,089,356,500	6,927,856,072
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*Total MO HealthNet Division*

227.11	1,328,371,763	3,808,010,216	2,198,592,462	7,334,974,441
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# **Crossing Issues**

# ***Caseload Growth***

**NEW DECISION ITEM  
RANK: 6**

Department: Social Services  
Division: MO HealthNet  
DI Name: Caseload Growth

Budget Unit: 90541C, 90544C, 90546C, 90547C, 90550C, 90551C  
90552C, 90556C, 90561C, 90564C  
DI#: 1886006

**1. AMOUNT OF REQUEST**

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	17,806,183	30,386,702		48,192,885
TRF				
<b>Total</b>	<b>17,806,183</b>	<b>30,386,702</b>		<b>48,192,885</b>
<b>FTE</b>				<b>0.00</b>

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
<b>Total</b>				
<b>FTE</b>				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

**2. THIS REQUEST CAN BE CATEGORIZED AS:**

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Growth with current eligibility guidelines	

**3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.**

*NDI SYNOPSIS: To provide for anticipated caseload increases in existing MO HealthNet Programs.*

This funding is requested to provide for anticipated caseload changes of existing MO HealthNet programs. This does not include any expansion due to changes in any eligibility guidelines. Caseload increases are projected in the Persons with Disabilities, Elderly, and Children populations for an average increase of 6,368 average per month. The Federal Authority is Social Security Act 1902(a)(10), 1903(w), 1905, 1915(d), 1915(b), 1923(a)-(f), 2100 and 1115 waiver; 42 CFR 406, 410, 412, 418, 431, 440, 441 subpart B and 434 subpart C. The State Authority is 208.151, 208.152, 208.153, 208.166, 167.600 thru 167.621, 191.831 RSMo.

**4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)**

Each category is forecasted individually. Total average per month increase is 6,368. The analysis utilized is listed below:

**Persons with Disabilities - FFS Participants**

- Number of participants is increased at 2.90% per year (estimated 2,708 average per month) based on historical trends.
- Costs per participant per month are adjusted by program based on historical trends. Managed Care is excluded due to participant category involved.
- Total costs for growth in this participant group are estimated at \$35.2 million.

**Elderly - FFS Participants**

- Number of participants is increased at .03% per year (estimated 12 average per month) based on historical trends.
- Costs per participant per month are adjusted by program based on historical trends. Managed Care is excluded due to participant category involved.
- Total costs for growth in this participant group are estimated at \$59,744.

**Children- FFS and Managed Care Participants**

- Number of participants is increased at 1.23% per year (estimated 3,185 average per month) based on historical trends.
- Costs per participant per month are adjusted by program based on historical trends.
- Total costs for growth in this participant group are estimated at \$11.7 million.

**Children Health Insurance Program (CHIP) - FFS and Managed Care Participants**

- Number of participants is increased at 1.23% per year (estimated 463 average per month) based on historical trends.
- Costs per participant per month are adjusted by program based on historical trends.
- Total costs for growth in this participant group are estimated at \$1.17 million.

	Total	GR	Federal
Pharmacy	11,880,981	4,422,101	7,458,880
Physician	6,665,157	2,480,771	4,184,386
Dental	163,660	60,914	102,746
Buy-In	1,801,163	670,393	1,130,770
Home Health	119,796	44,588	75,208
Rehab & Specialty	1,818,273	676,761	1,141,512
NEMT	257,079	95,685	161,394
Hospital	17,963,786	6,686,121	11,277,665
Managed Care	6,348,342	2,362,853	3,985,489
CHIP	1,174,648	305,996	868,652
Total	\$48,192,885	\$17,806,183	\$30,386,702

**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	17,806,183		30,386,702				48,192,885		
Total PSD	17,806,183		30,386,702		0		48,192,885		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	17,806,183	0.0	30,386,702	0.0	0	0.0	48,192,885	0.0	0

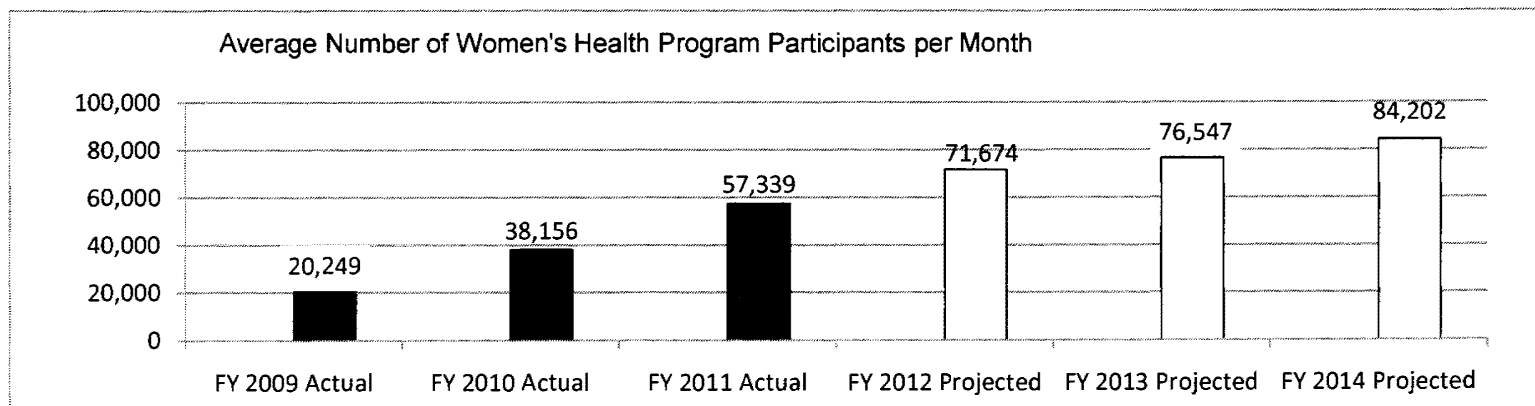
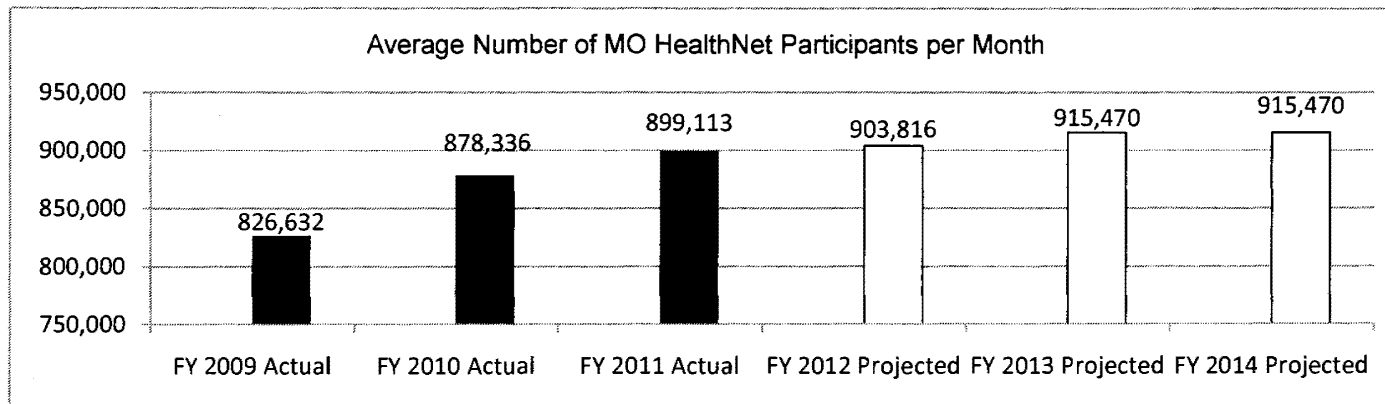
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

**6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)**

**6a. Provide an effectiveness measure.**

**6b. Provide an efficiency measure.**

**6c. Provide the number of clients/individuals served, if applicable.**



# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PHARMACY								
Caseload Growth - 1886006								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	11,880,981	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	11,880,981	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$11,880,981	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$4,422,101	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$7,458,880	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00



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## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PHYSICIAN RELATED PROF								
Caseload Growth - 1886006								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	6,665,157	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	6,665,157	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$6,665,157	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$2,480,771	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$4,184,386	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
DENTAL								
Caseload Growth - 1886006								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	163,660	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	163,660	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$163,660	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$60,914	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$102,746	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>PREMIUM PAYMENTS</b>								
Caseload Growth - 1886006								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	1,801,163	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	1,801,163	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$0</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	<b>\$1,801,163</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$670,393	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$1,130,770	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>HOME HEALTH</b>								
<b>Caseload Growth - 1886006</b>								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	119,796	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	119,796	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$0</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	<b>\$119,796</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$44,588	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$75,208	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
REHAB AND SPECIALTY SERVICES								
Caseload Growth - 1886006								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	1,818,273	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	1,818,273	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$1,818,273	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$676,761	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$1,141,512	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>NON-EMERGENCY TRANSPORT</b>								
<b>Caseload Growth - 1886006</b>								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	257,079	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	257,079	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$0</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	<b>\$257,079</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$95,685	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$161,394	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

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Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>MANAGED CARE</b>								
Caseload Growth - 1886006								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	6,348,342	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	6,348,342	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$6,348,342	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$2,362,853	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$3,985,489	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

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Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>HOSPITAL CARE</b>								
<b>Caseload Growth - 1886006</b>								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	17,963,786	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	17,963,786	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$0</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	<b>\$17,963,786</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$6,686,121	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$11,277,665	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00



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## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
CHILDREN'S HEALTH INS PROGRAM								
Caseload Growth - 1886006								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	1,174,648	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	1,174,648	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$1,174,648	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$305,996	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$868,652	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# ***Managed Care Actuarial Increase***

## NEW DECISION ITEM

RANK: 9

Department: Social Services  
 Division: MO HealthNet  
 DI Name: Managed Care Actuarial Increase

Budget Unit: 90551C, 90556C

DI#: 1886008

## 1. AMOUNT OF REQUEST

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	23,207,286	40,576,428		63,783,714
TRF				
Total	23,207,286	40,576,428		63,783,714

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				

FTE

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

Other Funds:

## 2. THIS REQUEST CAN BE CATEGORIZED AS:

☐ New Legislation  
☒ Federal Mandate  
☐ GR Pick-Up  
☐ Pay Plan

☐ New Program  
☐ Program Expansion  
☐ Space Request  
☒ Other: Actuarial Increase

☐ Fund Switch  
☐ Cost to Continue  
☐ Equipment Replacement

## 3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.

NDI SYNOPSIS: Funding is needed to fund an increase for Managed Care medical, delivery and Neonatal Intensive Care Unit services to ensure that managed care payments are actuarially sound. Funding is for the Eastern, Central and Western regions for July 2012 through June 2013.

MO HealthNet needs to maintain capitation rates at a sufficient level to ensure continued health plan and provider participation. The Federal Authority is Social Security Act Section 1915(b) and 1115 Waiver. The Federal Regulation is 42 CFR 438-Managed Care, and the State Authority is 208.166 RSMo. Final rules and regulations published June 14, 2002, effective August 13, 2003, require that capitation payments made on behalf of managed care participants be actuarially sound. Further, the state must provide the actuarial certification of the capitation rates to the CMS. The CMS Regional Office must review and approve all contracts for managed care as a condition for federal financial participation.

**4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)**

The chart below indicates the projected need for all medical services as well as the normal births of children and Neonatal Intensive Care Unit (NICU) care for newborns in need of specialized care. Pharmacy benefits were carved out of Managed Care beginning October 1, 2009; therefore, participants receive their pharmacy benefits through the fee-for-service program. The managed care trend factor need is calculated by region and is based on the number of months in the contract period that fall in FY 2013. The total cost is estimated at \$63,783,714 as follows:

Program	Region	FY12	FY13	Difference	Participants	Contract Months in FY13	Total
Medical-Managed Care	Eastern	\$200.58	\$210.03	\$9.45	205,590	12	\$23,313,906
Medical-Managed Care	Central	\$209.68	\$221.45	\$11.77	77,000	12	\$10,875,480
Medical-Managed Care	Western	\$226.92	\$240.35	\$13.43	130,692	12	\$21,062,323
<i>subtotal Managed Care</i>							\$55,251,709
Medical TIXXI CHIP-Child	Eastern	\$137.17	\$144.17	\$7.00	19,564	12	\$1,643,376
Medical TIXXI CHIP-Child	Central	\$140.91	\$149.08	\$8.17	11,776	12	\$1,154,519
Medical TIXXI CHIP-Child	Western	\$165.79	\$175.74	\$9.95	16,532	12	\$1,973,921
<i>subtotal TIXXI CHIP Children</i>							\$4,771,816
<b>Total Need Medical Trend</b>							<b>\$60,023,525</b>
Deliveries-Managed Care and CHIP	Eastern	\$4,672.10	\$4,728.17	\$56.07	1,019	12	\$685,624
Deliveries-Managed Care and CHIP	Central	\$3,885.32	\$3,951.37	\$66.05	438	12	\$347,159
Deliveries-Managed Care and CHIP	Western	\$3,671.52	\$3,708.24	\$36.72	699	12	\$308,007
<i>subtotal Managed Care and CHIP Deliveries</i>							\$1,340,790
<b>Total Need Deliveries Trend</b>							<b>\$1,340,790</b>
NICU-Managed Care and CHIP	Eastern	\$165,326.44	\$173,096.78	\$7,770.34	15	12	\$1,398,661
NICU-Managed Care and CHIP	Central	\$116,980.52	\$123,531.43	\$6,550.91	4	12	\$314,444
NICU-Managed Care and CHIP	Western	\$124,698.72	\$132,055.95	\$7,357.23	8	12	\$706,294
<i>subtotal Managed Care and CHIP Deliveries</i>							\$2,419,399
<b>Total Need NICU Trend</b>							<b>\$2,419,399</b>
<b>Total Need Medical, Deliveries and NICU</b>							<b><u>\$63,783,714</u></b>

	Total	GR	Federal
Managed Care	59,011,898	21,964,228	37,047,670
CHIP	4,771,816	1,243,058	3,528,758
	<b>\$63,783,714</b>	<b>\$23,207,286</b>	<b>\$40,576,428</b>

**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

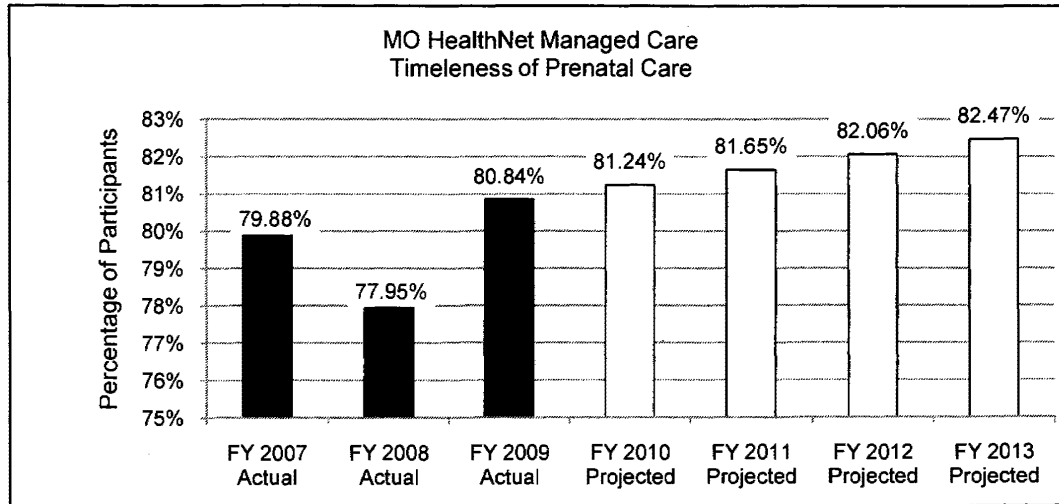
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	23,207,286		40,576,428				63,783,714		
Total PSD	23,207,286		40,576,428		0		63,783,714		0
Transfers							0		
Total TRF	0		0		0		0		0
Grand Total	23,207,286	0.0	40,576,428	0.0	0	0.0	63,783,714	0.0	0

Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions							0		
Total PSD	0		0		0		0		0
Transfers							0		
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

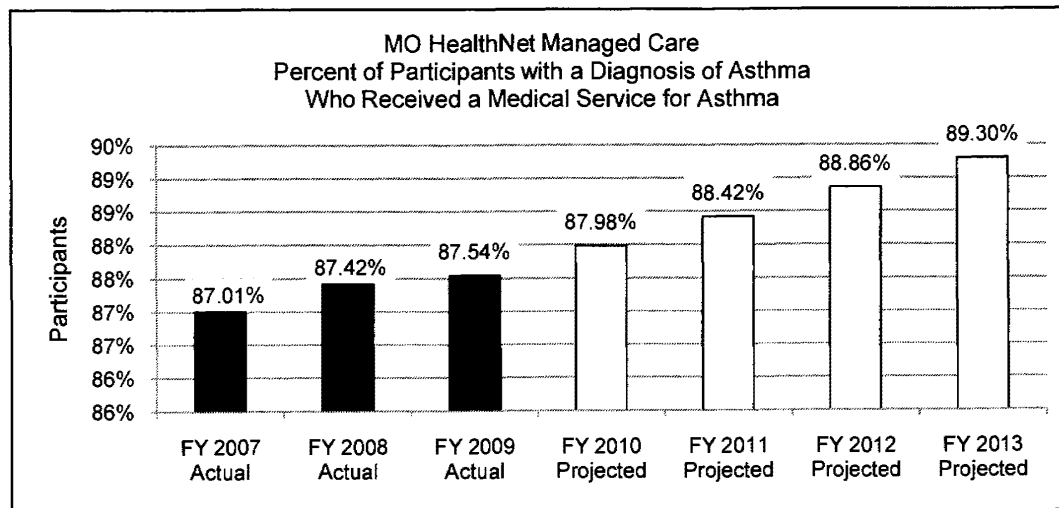
**6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)**

**6a. Provide an effectiveness measure.**

Prenatal care is important for monitoring the progress of pregnancy and to identify risk factors for the mother or baby before they become serious and lead to poor outcomes and more expensive health care costs. The diagnosis and treatment of chronic conditions also reduces more expensive health care costs that could result when conditions are left untreated.



Effectiveness Measure 1: Increase the percentage of women receiving prenatal care. The percentage of women who received prenatal care within the first trimester or within 42 days of enrollment in a health plan was nearly 81% in FY 2009.

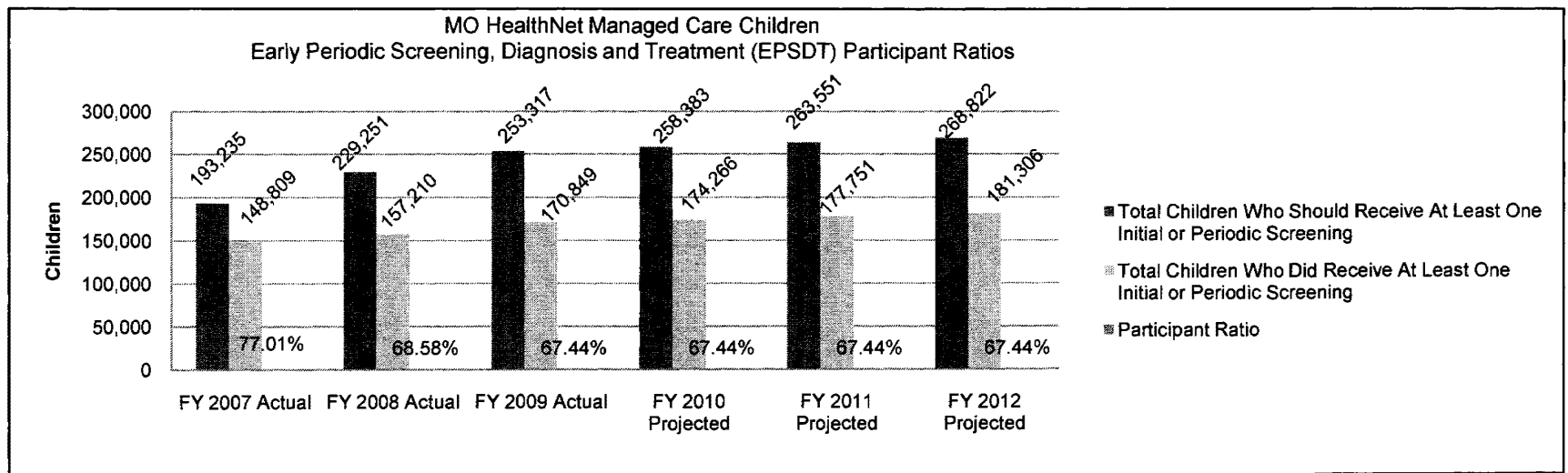


Effectiveness Measure 2: Increase the percentage of participants with chronic conditions who receive treatment for their condition. The percentage of participants with a diagnosis of asthma who received a medical service for asthma was 87.54% in FY 2009.

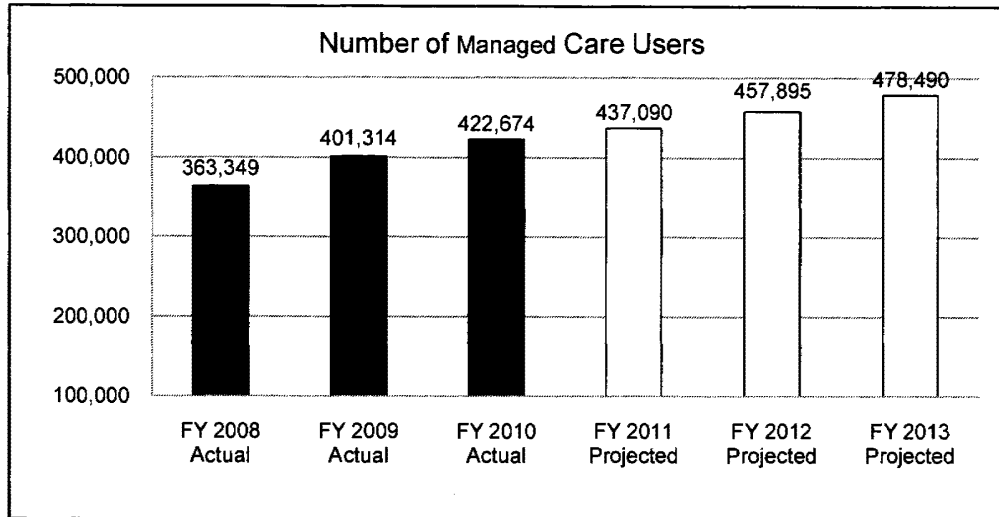
**6b. Provide an efficiency measure.**

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program is a comprehensive, primary and preventive health care program for MO HealthNet eligible children and youth under the age of 21 years. The program provides early and periodic medical/dental screenings, diagnosis and treatment to correct or ameliorate defects and chronic conditions found during the screening. The chart below does not include CHIP children.

Efficiency Measure: Increase the ratio of children who receive an EPSDT service. In FY 2009, over 67% of the children in Managed Care (not including CHIP) received an EPSDT screening.



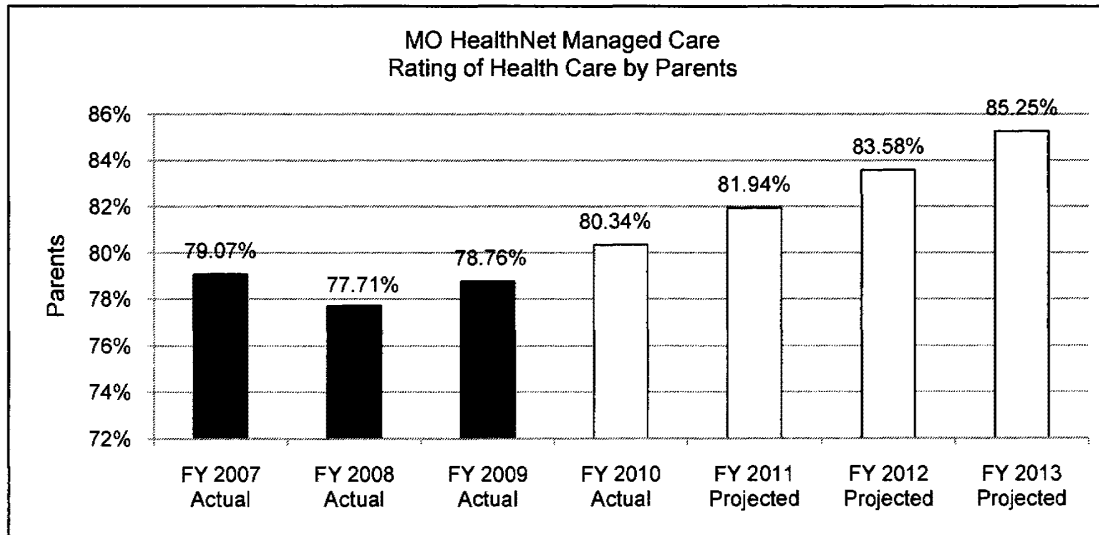
6c. Provide the number of clients/individuals served, if applicable.



Users include MO HealthNet (Title XIX) and CHIP (Title XXI) participants.

6d. Provide a customer satisfaction measure, if available.

When parents were asked if they were satisfied with the health care their child received through their MO HealthNet Managed Care plan, nearly 79% responded that they were satisfied in 2009.



Customer Satisfaction Measure: Increase the percentage of parents who were satisfied with the health care their child received through MO HealthNet Managed Care.



#### **7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:**

- Participate in the Statewide Coalition, consisting of leaders from Missouri Hospital Association and the Family and Community Trust to provide outreach and enrollment.
- Purchase cost effective health insurance policies for MO HealthNet participants through the Health Insurance Premium Payment Program.
- Continue to work with community groups, local medical providers, health care associations, schools, etc., regarding access to MO HealthNet coverage.
- Continue to work with MO HealthNet Managed Care health plans to provide outreach and education to communities regarding access to MO HealthNet coverage.

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## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>MANAGED CARE</b>								
Managed Care Actuarial Increas - 1886008								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	59,011,898	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	59,011,898	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$0</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	<b>\$59,011,898</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$21,964,228	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$37,047,670	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

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Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
CHILDREN'S HEALTH INS PROGRAM								
Managed Care Actuarial Increas - 1886008								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	4,771,816	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	4,771,816	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$4,771,816	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$1,243,058	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$3,528,758	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

***Pharmacy PMPM Increase***

**NEW DECISION ITEM**

**RANK: 10**

Department: Social Services  
Division: MO HealthNet  
DI Name: Pharmacy PMPM Increase

Budget Unit: 90541C, 90554C, 90556C, 90585C

DI#: 1886014

**1. AMOUNT OF REQUEST**

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	14,441,874	24,258,306		38,700,180
TRF				
<b>Total</b>	<b>14,441,874</b>	<b>24,258,306</b>		<b>38,700,180</b>
<b>FTE</b>				<b>0.00</b>

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
<b>Total</b>				
<b>FTE</b>				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

**2. THIS REQUEST CAN BE CATEGORIZED AS:**

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Inflation/Utilization	

**3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.**

*NDI SYNOPSIS: Funds are needed to address the anticipated increases in the pharmacy program due to new drugs, therapies and inflation.*

This decision item requests funding for the ongoing inflation of pharmaceuticals and the anticipated increase in pharmacy expenditures due to increased utilization.

**4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)**

Pharmacy costs continue to grow at a higher rate than other medical costs. The increasing costs can be attributed to the rising cost of drug ingredients, an increase in units per prescription, the cost of new, expensive medications, and utilization increases. The increase in ingredient costs is due to the inflationary increases which are incorporated into the overall pricing of prescription medications by the pharmaceutical industry as well as the addition of new, expensive agents to the marketplace.

The pharmacy pmpm decision item is based on historical trends. Over the last four years, the average increase in the pmpm cost has been 9.87% for the elderly population and 3.72% for the disabled population.

	Elderly	% Increase	Disabled	% Increase
FY07	\$142.13		\$398.12	
FY08	\$166.96	17.47%	\$423.07	6.27%
FY09	\$172.75	3.47%	\$440.34	4.08%
FY10	\$194.11	12.36%	\$455.20	3.37%
FY11	\$206.09	6.17%	\$460.43	1.15%
Average		9.87%		3.72%

The pharmacy benefit was carved out of managed care in October 2009. In order to calculate a trend projection for the other population, MHD compared the pmpm cost of the populations served by managed care plans for November 2009 through June 2010 to arrive at the pmpm cost for FY2011. This equated to an increase of 4.37%, which was used in the calculations for FY13. The pmpm increases are calculated below:

Calculation:

	Elderly	% Increase	Disabled	% Increase	Other	% Increase
FY11	\$206.09		\$460.43		\$45.53	
FY12 (Projection)	\$226.43	9.87%	\$477.56	3.72%	\$47.52	4.37%
FY13 (Projection)	\$248.78	9.87%	\$495.33	3.72%	\$49.60	4.37%
Increase	\$22.35		\$17.77		\$2.08	
FY12 Eligibles	9,852		90,446		671,922	
Cost per Month	220,192		1,607,225		1,397,598	
Months in Year	12		12		12	
Annual Cost	\$2,642,304		\$19,286,700		\$16,771,176	\$38,700,180 Total Request

	Total	GR	Federal
Pharmacy	36,401,389	13,548,597	22,852,792
State Medical	433,442	433,442	0
Women Health Services	162,541	16,254	146,287
CHIP	1,702,808	443,581	1,259,227
Total	\$38,700,180	\$14,441,874	\$24,258,306

**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
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Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
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Total EE	0		0		0		0		0
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Program Distributions	14,441,874		24,258,306				38,700,180		
Total PSD	14,441,874		24,258,306		0		38,700,180		0

Transfers									
Total TRF	0		0		0		0		0

Grand Total	14,441,874	0.0	24,258,306	0.0	0	0.0	38,700,180	0.0	0
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Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
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Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
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Total EE	0		0		0		0		0
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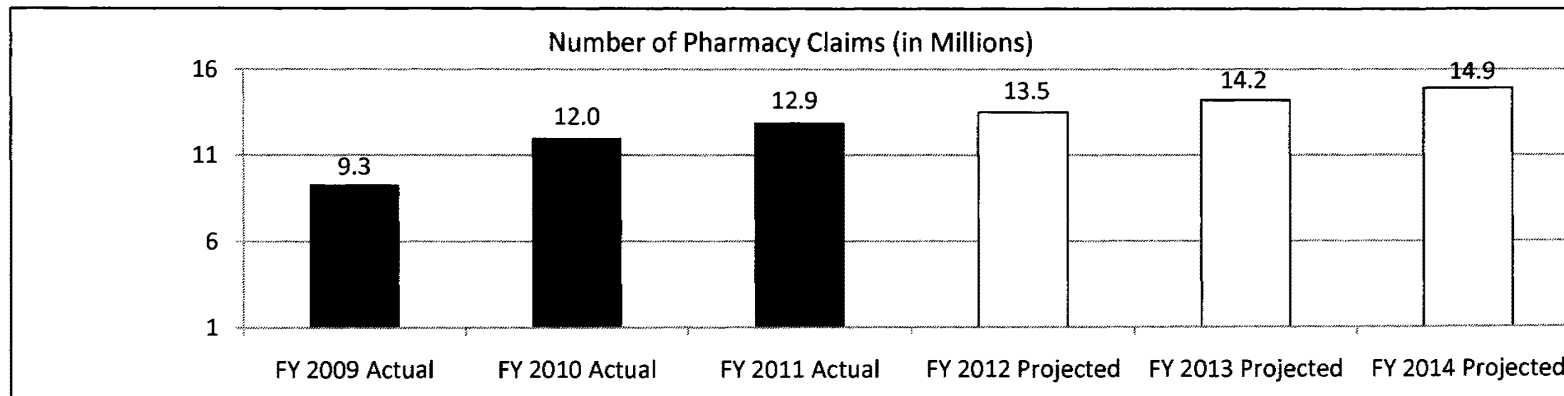
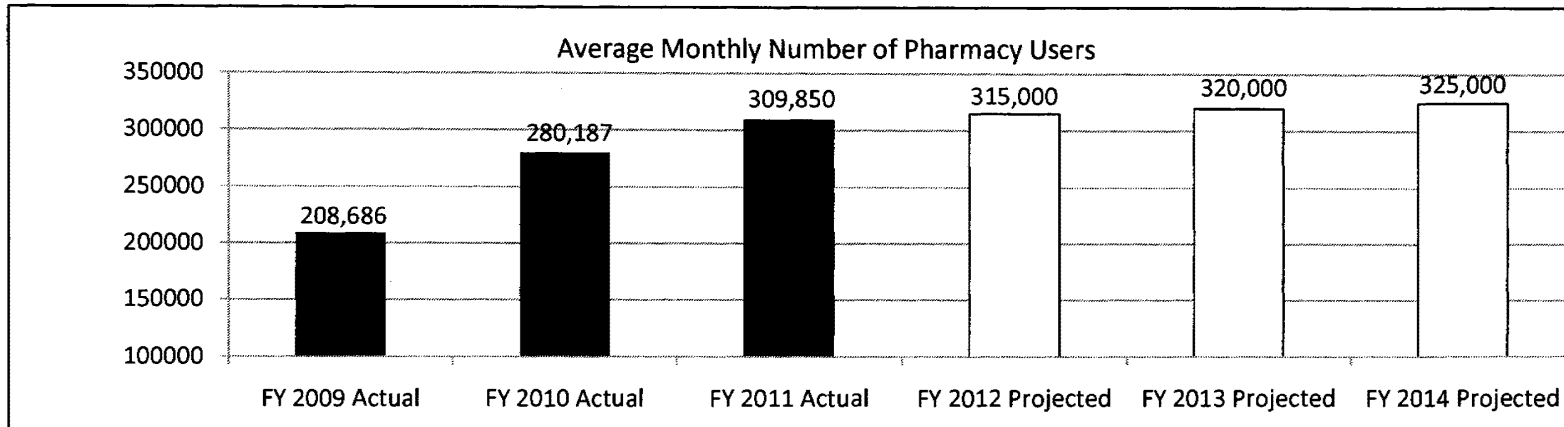
Program Distributions									
Total PSD	0		0		0		0		0

Transfers									
Total TRF	0		0		0		0		0

Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0
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**6c. Provide the number of clients/individuals served, if applicable.**

Pharmacy services are available to all MO HealthNet participants. Prior to FY 2010, managed care plans had the option to carve out pharmacy services. Beginning in SFY 2010, managed care plans are no longer responsible for paying for pharmacy services. Pharmacy services for both fee-for-service and managed care will be paid from the pharmacy section



**6d. Provide a customer satisfaction measure, if available.**

**7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:**



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## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>PHARMACY</b>								
Pharmacy PMPM Increase - 1886014								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	36,401,389	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	36,401,389	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$0</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	<b>\$36,401,389</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$13,548,597	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$22,852,792	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>WOMEN'S HEALTH SRVC</b>								
<b>Pharmacy PMPM Increase - 1886014</b>								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	162,541	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	162,541	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$0</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	<b>\$162,541</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$16,254	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$146,287	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
CHILDREN'S HEALTH INS PROGRAM								
Pharmacy PMPM Increase - 1886014								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	1,702,808	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	1,702,808	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$1,702,808	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$443,581	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$1,259,227	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
STATE MEDICAL								
Pharmacy PMPM Increase - 1886014								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	433,442	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	433,442	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$433,442	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$433,442	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# ***Sustaining MO HealthNet Technology Infrastructure***

**NEW DECISION ITEM**

**RANK: 14**

**Department: Social Services**

**Division: MO HealthNet**

**DI Name: Sustaining MO HealthNet Technology Infrastructure**

**Budget Unit: 90516C, 90522C**

**DI#: 1886015**

**1. AMOUNT OF REQUEST**

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE	4,687,500	22,500,000		27,187,500
PSD				
TRF				
<b>Total</b>	<b>4,687,500</b>	<b>22,500,000</b>		<b>27,187,500</b>

**FTE** **0.00**

<b>Est. Fringe</b>	0	0	0	0
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*Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.*

Other Funds:

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
<b>Total</b>				

**FTE**

<b>Est. Fringe</b>	0	0	0	0
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*Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.*

Other Funds:

**2. THIS REQUEST CAN BE CATEGORIZED AS:**

<input checked="" type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input checked="" type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input checked="" type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

**3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.**

*NDI SYNOPSIS: Funding is requested to ensure that the Medicaid Management Information System (MMIS) is in compliance with federal requirements and to continue funding technology initiatives for better care management/care coordination.*

**MMIS Compliance**

- ICD-10: Under final rule 45 CFR Part 162.1002, state Medicaid systems must adopt the International Classification of Diseases and Related Health Problems, Tenth Revision, Clinical Modification (ICD-10-CM) and Procedure Coding (ICD-10-PCS).

- Medicaid Information Technology Architecture (MITA) Self-Assessment: Under sections 1903(a)(3)(A)(in) and 1903(a)(3)(B) of the Social Security Act, the Centers for Medicare and Medicaid Services (CMS) has issued new standards and conditions that must be met by states in order for Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for the enhanced match funding.
- Independent Verification and Validation (IV & V): 45 CFR Part 95.626 recommends the application of IV&V services to Medicaid Management Information System (MMIS) projects.
- MMIS Reprocurement: Funding is requested for an independent review for reprocurement of the MMIS contract. Early planning will ensure that Missouri has the time to procure and implement the most efficient/effective MMIS.

#### Continue Funding Care Management/Coordination Technology Initiatives

Funding is requested to replace one time Health Care Technology funds that supported use of technology in healthcare including electronic health records, e-prescribing and CyberAccess.

**4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)**

ICD-10

The Federal Department of Health and Human Services (DHHS) published a final rule under 45 CFR Part 162.1002 under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act (HIPAA) requiring implementation of the following:

- International Classification of Diseases and Related Health Problems, 10th Edition, Clinical Modifications (ICD-10-CM) Diagnosis
- International Classification of Diseases and Related Health Problems, 10th Edition, Procedure Coding System (ICD-10-PCS) Inpatient Hospital Procedure Coding System

The final rule requires implementation of these ICD-10 code sets by October 1, 2013 for all state Medicaid programs and their healthcare service providers. The ICD-10 code sets will replace the ICD-9 code sets currently used throughout the healthcare industry as diagnosis and inpatient hospital procedure codes. The ICD-10 code sets expand significantly on the existing ICD-9 code sets by adding thousands of new codes and by allowing for the encoding of a significant amount of additional data regarding a diagnosis and an inpatient procedure.

DSS continues to refine ICD-10 costs. The DSS estimate is based on Iowa's experience.

Medicaid Information Technology Architecture (MITA) Self-Assessment

Under sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Social Security Act, CMS has issued new standards and conditions that must be met by the states in order for Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for the enhanced match funding. These seven new standards and conditions include a modular and flexible approach to system development; alignment with MITA and advancement in MITA maturity; alignment with industry standards including HIPAA security, privacy, and transaction standards; promotion of sharing, reuse, and leverage of solutions across States; support of effective and efficient business processes; production of timely and accurate reports for support of business needs; and support of interoperability with the Health Insurance Exchange and other systems. These conditions and standards will require the completion of a MITA self-assessment within 12 months of the issuance of MITA 3.0 and ongoing investments in system upgrades to meet the seven standards and conditions and advance the MMIS in the MITA Maturity Model.

Independent Verification and Validation (IV & V)

45 CFR Part 95.626 recommends the application of IV&V services to MMIS projects at risk of missing regulatory deadlines and projects involving MMIS redesign. MHD currently has two such projects – implementation of the ICD-10 code set as required by the Administrative Simplification provision of HIPAA and implementation of the Patient Protection and Affordable Care Act – that will be active during State Fiscal Year 2013. The State of Missouri also committed to procuring IV&V services to monitor the MMIS Reengineering projects being implemented as part of a redesign and enhancement of the MMIS. The requested funding would expand the scope of the IV&V services to encompass the Clinical Management System for Pharmacy Claims and Prior Authorization (CMSP).



### MMIS Reprocurement

The contract with Wipro Infocrossing, Inc. for the operation of the primary MMIS, Medicaid call centers, and Managed Care Enrollment Broker will expire on June 30, 2014 with options to renew annually for up to three additional years. The contract with ACS Inc. for the operation of CMSP will expire on June 30, 2012 with options to renew annually for up to six additional years. Due to the complexity and potential cost of these contracts, a thorough independent review of the renewal options available to Missouri for provision of these services is strongly recommended. Given the length of time required to select a renewal option and to exercise the selected option such as an estimated three to five-year implementation of a replacement system, the reprocurement effort must be initiated several years prior to the end of the contract period and the available contract renewal periods.

### Health Care Technology

GR is requested to replace one-time Health Care Technology Funds used to support technology in healthcare, facilitating better care coordination and care management. Initiatives include electronic health records, community health records, personal health records and e-prescribing, integration of assessment and authorization processes for home and community based services with other MO HealthNet programs and CyberAccess (provider focused tool) and a pilot participant-focused tool allowing individuals to access their own health information and receive individually-tailored educational and health and wellness materials via a secure web-based portal.

<u>Appropriation</u>		Total	GR	Federal
Information Systems	ICD-10	\$24,000,000	\$2,400,000	\$21,600,000
	MMIS Reprocurement	\$500,000	\$50,000	\$450,000
	MITA Self-Assessment	\$200,000	\$20,000	\$180,000
	IV & V	\$300,000	\$30,000	\$270,000
Clincial Services	Health Care Technology	\$2,187,500	\$2,187,500	\$0
	Total	\$27,187,500	\$4,687,500	\$22,500,000

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.								
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE

<b>Total PS</b>	0	0.0	0	0.0	0	0.0	0	0.0
Professional Services (400)	4,687,500		22,500,000				27,187,500	
<b>Total EE</b>	<b>4,687,500</b>		<b>22,500,000</b>		0		<b>27,187,500</b>	
Program Distributions	0		0		0		0	
<b>Total PSD</b>	<b>0</b>		<b>0</b>		<b>0</b>		<b>0</b>	
Transfers								
<b>Total TRF</b>	<b>0</b>		<b>0</b>		<b>0</b>		<b>0</b>	
<b>Grand Total</b>	<b>4,687,500</b>	<b>0.0</b>	<b>22,500,000</b>	<b>0.0</b>	<b>0</b>	<b>0.0</b>	<b>27,187,500</b>	<b>0.0</b>

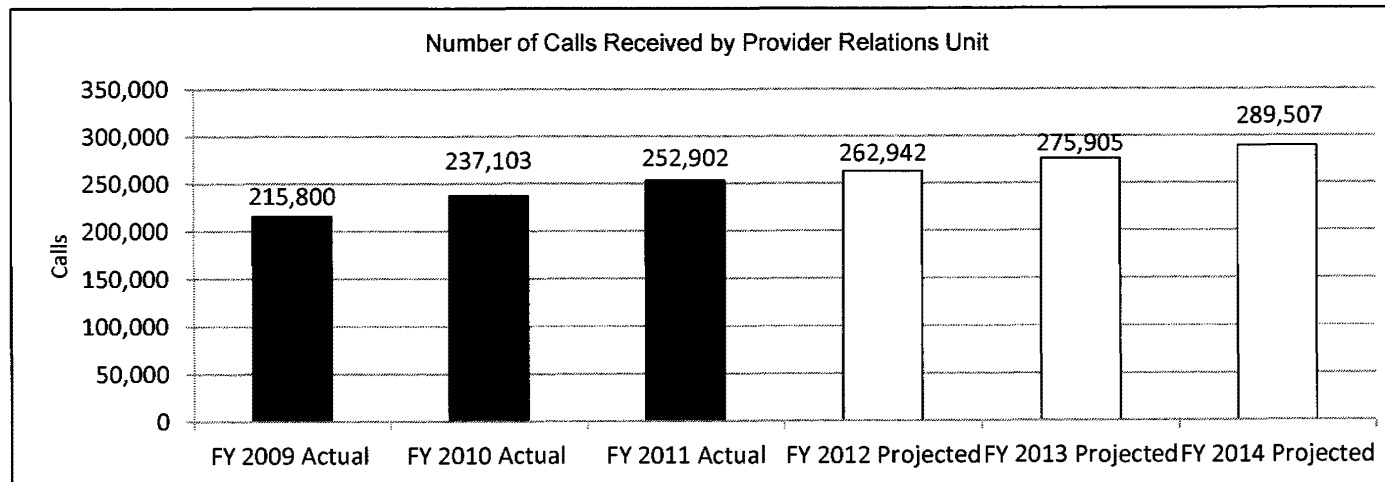
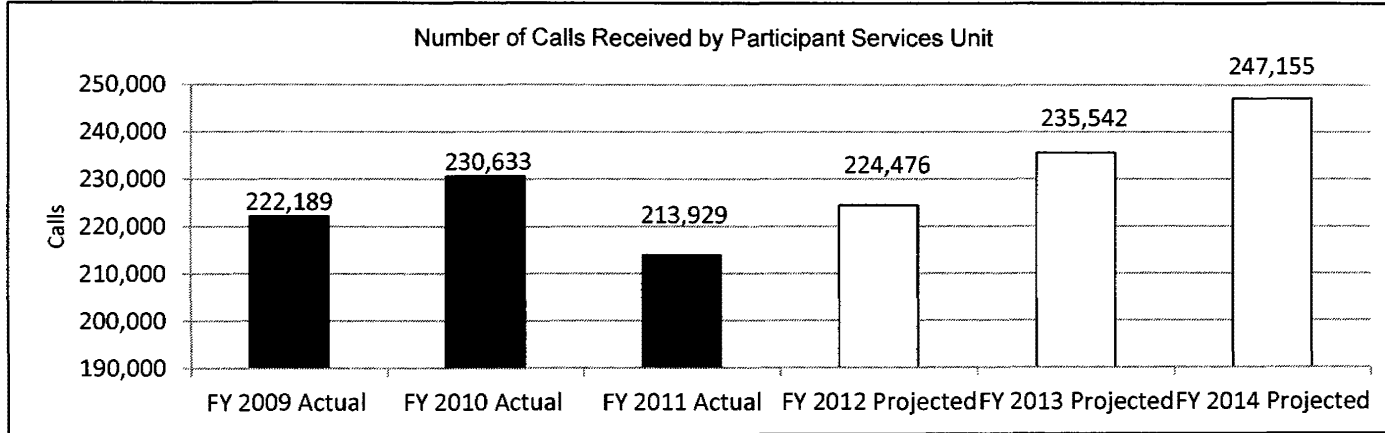
5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.								
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE

<b>Total PS</b>	0	0.0	0	0.0	0	0.0	0	0.0
<b>Total EE</b>	0		0		0		0	
Program Distributions								
<b>Total PSD</b>	<b>0</b>		<b>0</b>		<b>0</b>		<b>0</b>	
Transfers								
<b>Total TRF</b>	<b>0</b>		<b>0</b>		<b>0</b>		<b>0</b>	
<b>Grand Total</b>	<b>0</b>	<b>0.0</b>	<b>0</b>	<b>0.0</b>	<b>0</b>	<b>0.0</b>	<b>0</b>	<b>0.0</b>

**6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)**

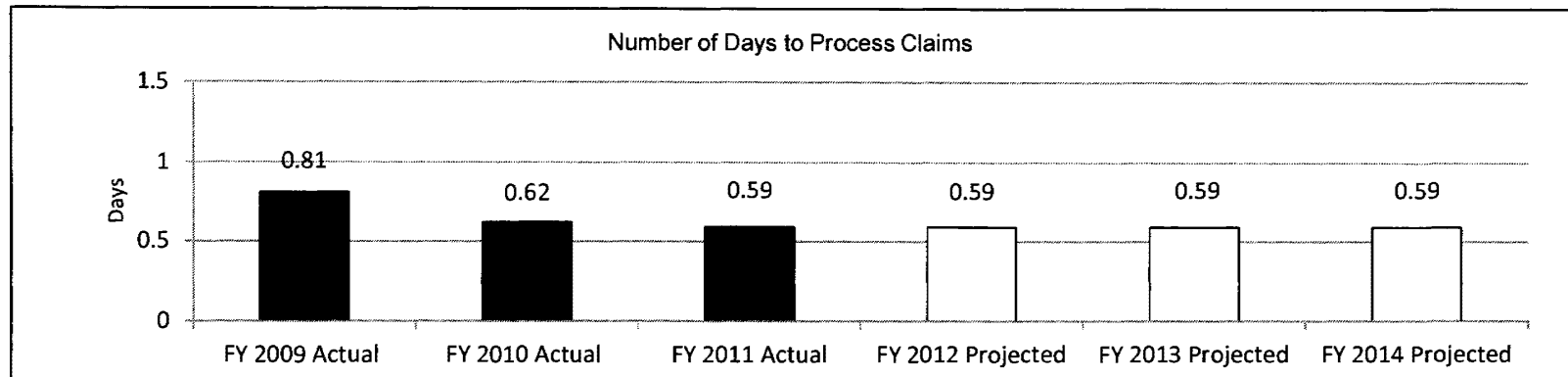
**6a. Provide an effectiveness measure.**

Effectiveness Measure: Provide support for participants and providers. For each of the past three state fiscal years, the Participant Services Unit received and responded to over 215,000 calls from participants. The Provider Relations Unit received and responded to over 250,000 calls in SFY 2011.

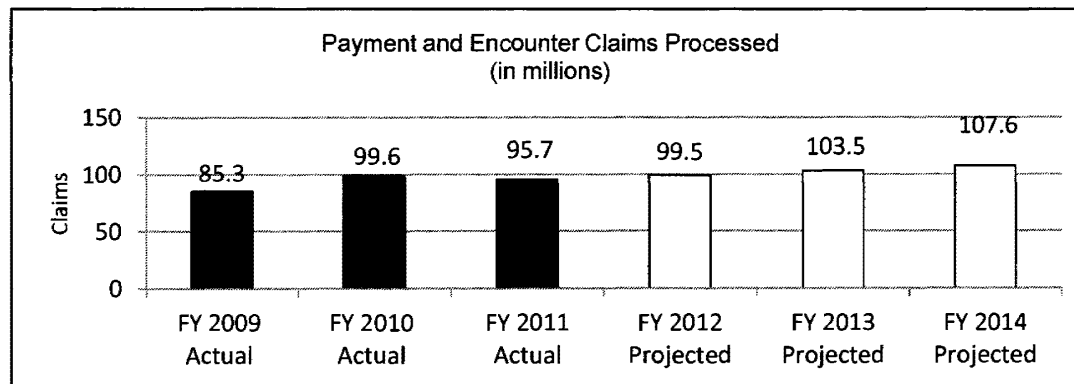


**6b. Provide an efficiency measure.**

Efficiency Measure: Promptly process "clean" claims in less than one day. For the past three fiscal years, claims passing system edits have been processed in less than one day. Processed claims are paid twice a month. In SFY 2011, over 95.7 million claims were processed.



**6c. Provide the number of clients/individuals served, if applicable.**



**6d. Provide a customer satisfaction measure, if available.**

**7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:**

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
CLINICAL SRVC MGMT								
Sustain MHD Tech Infrastructur - 1886015								
PROFESSIONAL SERVICES	0	0.00	0	0.00	2,187,500	0.00	0	0.00
TOTAL - EE	0	0.00	0	0.00	2,187,500	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$2,187,500	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$2,187,500	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>INFORMATION SYSTEMS</b>								
Sustain MHD Tech Infrastructur - 1886015								
PROFESSIONAL SERVICES	0	0.00	0	0.00	25,000,000	0.00	0	0.00
TOTAL - EE	0	0.00	0	0.00	25,000,000	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$25,000,000	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$2,500,000	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$22,500,000	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# ***Medicaid Primary Care Rate Increase***

**NEW DECISION ITEM  
RANK: 16**

Department: Social Services  
Division: MO HealthNet  
DI Name: Medicaid Primary Care Rate Increase

Budget Unit: 90544C, 90551C  
DI#: 1886016

**1. AMOUNT OF REQUEST**

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD		50,730,012		50,730,012
TRF				
<b>Total</b>		<b>50,730,012</b>		<b>50,730,012</b>
<b>FTE</b>				<b>0.00</b>

<b>Est. Fringe</b>	0	0	0	0
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*Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.*

Other Funds:

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
<b>Total</b>				
<b>FTE</b>				

<b>Est. Fringe</b>	0	0	0	0
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*Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.*

Other Funds:

**2. THIS REQUEST CAN BE CATEGORIZED AS:**

<input checked="" type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input checked="" type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

**3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.**

NDI SYNOPSIS: Funding is needed to increase primary care provider reimbursement to reach parity with Medicare rates in 2013 and 2014.

Federal law requires that Medicaid reimburse primary care providers (PCPs) at parity with Medicare rates in 2013 and 2014.



**4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)**

Federal law requires payments for primary care services furnished by a physician with a primary specialty of family medicine, general internal medicine, or pediatric medicine be paid at parity with Medicare beginning January 1, 2013. Covered services are defined as those Evaluation and Management (E&M) codes and immunization services that are covered by Medicare. In addition, the law provides 100% federal funding for the incremental cost of meeting this requirement. The 100% federal funding of the incremental cost is calculated based on the Medicaid rate as of July 1, 2009.

Data was obtained from the MMIS system which provided the CY 2010 number of units, 7/1/09 Medicaid rate and the Medicare rate for the procedure codes which are defined as covered services in Section 1202. The cost to increase the 7/1/09 Medicaid rate to the Medicare rate was determined by taking the difference in the rates and multiplying by the number of units. This cost was inflated by 3.6% annually to arrive at an annual FY 13 cost. In addition, a managed care cost was calculated. FY 13 cost is \$50,730,012. This represents 6 months of cost as this requirement is effective the last 6 months of FY2013.

	Total	GR	Federal
Physician	35,394,115		35,394,115
Managed Care	15,335,897	0	15,335,897
Total	\$50,730,012	\$0	\$50,730,012

**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	0		50,730,012		0		50,730,012		
Total PSD	0		50,730,012		0		50,730,012		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	50,730,012	0.0	0	0.0	50,730,012	0.0	0

**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

**6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)**

- 6a. Provide an effectiveness measure.
- 6b. Provide an efficiency measure.
- 6c. Provide the number of clients/individuals served, if applicable.
- 6d. Provide a customer satisfaction measure, if available.

**7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:**

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PHYSICIAN RELATED PROF								
Medicaid Primary Care Rate Inc - 1886016								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	35,394,115	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	35,394,115	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$35,394,115	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$35,394,115	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>MANAGED CARE</b>								
<b>Medicaid Primary Care Rate Inc - 1886016</b>								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	15,335,897	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	15,335,897	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$0</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	<b>\$15,335,897</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$15,335,897	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# **MO HealthNet Administration**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>MO HEALTHNET ADMIN</b>								
<b>CORE</b>								
<b>PERSONAL SERVICES</b>								
GENERAL REVENUE	3,171,801	78.84	2,679,454	64.53	2,679,454	64.53	0	0.00
DEPT OF SOC SERV FEDERAL & OTH	5,116,191	127.10	4,915,726	118.49	4,915,726	118.49	0	0.00
THIRD PARTY LIABILITY COLLECT	359,605	8.95	372,582	12.29	372,582	12.29	0	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	10,380	0.22	92,019	2.00	92,019	2.00	0	0.00
PHARMACY REIMBURSEMENT ALLOWAN	24,126	0.57	25,101	0.50	25,101	0.50	0	0.00
NURSING FAC QUALITY OF CARE	77,666	1.94	80,513	2.45	80,513	2.45	0	0.00
HEALTH INITIATIVES	284,161	7.06	303,795	9.35	303,795	9.35	0	0.00
MISSOURI RX PLAN FUND	665,523	16.40	730,059	17.00	730,059	17.00	0	0.00
AMBULANCE SERVICE REIMB ALLOW	0	0.00	17,211	0.50	17,211	0.50	0	0.00
TOTAL - PS	9,709,453	241.08	9,216,460	227.11	9,216,460	227.11	0	0.00
<b>EXPENSE &amp; EQUIPMENT</b>								
GENERAL REVENUE	1,064,562	0.00	794,081	0.00	794,081	0.00	0	0.00
DEPT OF SOC SERV FEDERAL & OTH	3,551,475	0.00	3,367,527	0.00	3,367,527	0.00	0	0.00
THIRD PARTY LIABILITY COLLECT	490,743	0.00	495,188	0.00	495,188	0.00	0	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	8,114	0.00	8,114	0.00	8,114	0.00	0	0.00
PHARMACY REIMBURSEMENT ALLOWAN	375	0.00	375	0.00	375	0.00	0	0.00
NURSING FAC QUALITY OF CARE	10,281	0.00	10,281	0.00	10,281	0.00	0	0.00
HEALTH INITIATIVES	26,220	0.00	31,385	0.00	31,385	0.00	0	0.00
MISSOURI RX PLAN FUND	40,317	0.00	57,800	0.00	57,800	0.00	0	0.00
AMBULANCE SERVICE REIMB ALLOW	0	0.00	3,474	0.00	3,474	0.00	0	0.00
TOTAL - EE	5,192,087	0.00	4,768,225	0.00	4,768,225	0.00	0	0.00
<b>PROGRAM-SPECIFIC</b>								
DEPT OF SOC SERV FEDERAL & OTH	0	0.00	1,030	0.00	1,030	0.00	0	0.00
TOTAL - PD	0	0.00	1,030	0.00	1,030	0.00	0	0.00
<b>TOTAL</b>	<b>14,901,540</b>	<b>241.08</b>	<b>13,985,715</b>	<b>227.11</b>	<b>13,985,715</b>	<b>227.11</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$14,901,540</b>	<b>241.08</b>	<b>\$13,985,715</b>	<b>227.11</b>	<b>\$13,985,715</b>	<b>227.11</b>	<b>\$0</b>	<b>0.00</b>

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: MO HealthNet Administration

Budget Unit: 90512C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS	2,679,454	4,915,726	1,621,280	9,216,460
EE	794,081	3,367,527	606,617	4,768,225
PSD		1,030		1,030
TRF				
Total	3,473,535	8,284,283	2,227,897	13,985,715
FTE	64.53	118.49	44.09	227.11

<b>Est. Fringe</b>	1,494,867	2,742,484	904,512	5,141,863
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total	0	0	0	0
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Pharmacy Reimbursement Allowance Fund (0144)  
Health Initiatives Fund (HIF) (0275)  
Nursing Facility Quality of Care Fund (NFQC) (0271)  
Third Party Liability Collections Fund (TPL) (0120)  
MO Rx Plan Fund (0779)  
Federal Reimbursement Allowance Fund (FRA) (0142)  
Ambulance Service Reimbursement Allowance Fund (0958)

## 2. CORE DESCRIPTION

This core request is for the continued operation of the MO HealthNet program. The MO HealthNet Division seeks to aid participants and providers in their efforts to access the MO HealthNet program by utilizing administrative staffing, expense and equipment and contractor resources effectively.

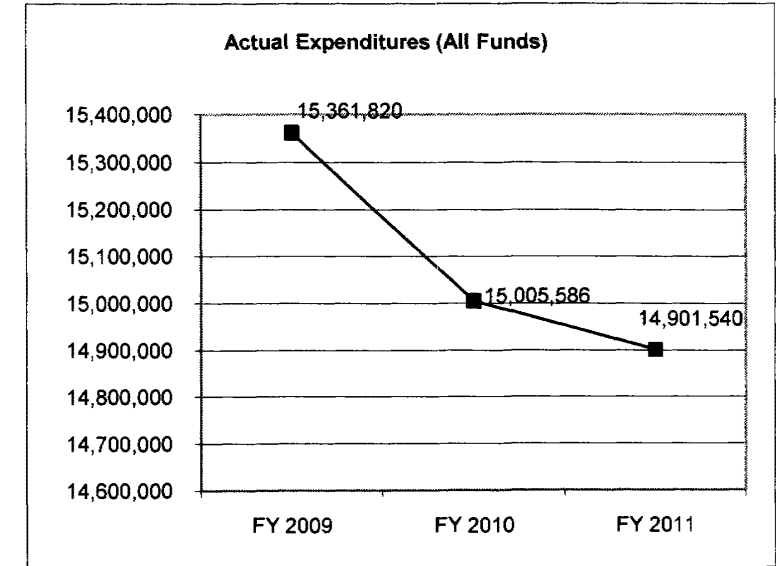
## 3. PROGRAM LISTING (list programs included in this core funding)

MO HealthNet Administration



#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	16,457,280	16,385,259	16,444,060	13,985,715
Less Reverted (All Funds)	(406,711)	(517,300)	(199,876)	N/A
Budget Authority (All Funds)	16,050,569	15,867,959	16,244,184	N/A
Actual Expenditures (All Funds)	15,361,820	15,005,586	14,901,540	N/A
Unexpended (All Funds)	688,749	862,373	1,342,644	N/A
Unexpended, by Fund:				
General Revenue	3,714	3,405	117,586	N/A
Federal	611,126	802,463	1,004,728	N/A
Other	73,909	56,505	220,330	N/A
	(1) (2)	(3)	(4)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

- (1) Agency reserve of \$438,387 in E & E; general revenue of \$3,689; federal funds \$420,675; MO Rx Plan funds \$10,000 and \$4,023 in Health Initiatives funds.
- (2) FY2009 increases: \$758,000 for SB 577 (2007) implementation; \$300,000 pay plan. Reduction for actuarial study completed in FY2008.
- (3) Agency reserve of \$792,218: federal funds \$328,789 in PS and \$450,929 in E & E; MO Rx Plan funds \$2,500 in PS and \$10,000 in E & E.
- (4) Agency reserve of \$730,199: federal funds \$456,000 in PS and \$155,152 in E & E; Federal Reimbursement Allowance funds \$81,639 in PS; Health Initiatives Funds \$4,223 in E & E; MO Rx Plan funds \$2,500 in PS and \$10,000 in E & E; Ambulance Reimbursement Allowance Funds \$17,211 in PS and \$3,474 in E & E.

**CORE RECONCILIATION DETAIL**

**DEPARTMENT OF SOCIAL SERVICES**

**MO HEALTHNET ADMIN**

**5. CORE RECONCILIATION DETAIL**

	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PS	227.11	2,679,454	4,915,726	1,621,280	9,216,460	
	EE	0.00	794,081	3,367,527	606,617	4,768,225	
	PD	0.00	0	1,030	0	1,030	
	<b>Total</b>	<b>227.11</b>	<b>3,473,535</b>	<b>8,284,283</b>	<b>2,227,897</b>	<b>13,985,715</b>	

**DEPARTMENT CORE ADJUSTMENTS**

Core Reallocation	781 1670	PS	(0.00)	0	0	0	0
Core Reallocation	781 1753	PS	0.00	0	0	0	0
Core Reallocation	781 2849	PS	(0.00)	0	0	0	0
Core Reallocation	781 6376	PS	0.00	0	0	0	0
Core Reallocation	781 6378	PS	0.00	0	0	0	0
Core Reallocation	781 6884	PS	0.00	0	0	0	0
Core Reallocation	781 6889	PS	0.00	0	0	0	(0)
Core Reallocation	781 1387	PS	(0.00)	0	0	0	0
<b>NET DEPARTMENT CHANGES</b>			<b>0.00</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**DEPARTMENT CORE REQUEST**

	PS	227.11	2,679,454	4,915,726	1,621,280	9,216,460	
	EE	0.00	794,081	3,367,527	606,617	4,768,225	
	PD	0.00	0	1,030	0	1,030	
	<b>Total</b>	<b>227.11</b>	<b>3,473,535</b>	<b>8,284,283</b>	<b>2,227,897</b>	<b>13,985,715</b>	

**GOVERNOR'S RECOMMENDED CORE**

	PS	227.11	2,679,454	4,915,726	1,621,280	9,216,460	
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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES****MO HEALTHNET ADMIN**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	EE	0.00	794,081	3,367,527	606,617	4,768,225	
	PD	0.00	0	1,030	0	1,030	
	<b>Total</b>	<b>227.11</b>	<b>3,473,535</b>	<b>8,284,283</b>	<b>2,227,897</b>	<b>13,985,715</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>MO HEALTHNET ADMIN</b>								
<b>CORE</b>								
OFFICE SUPPORT ASST (CLERICAL)	34,878	1.51	34,866	1.00	23,065	1.00	0	0.00
SR OFC SUPPORT ASST (CLERICAL)	30,573	1.24	32,566	1.36	24,656	1.00	0	0.00
ADMIN OFFICE SUPPORT ASSISTANT	146,376	5.17	149,541	5.02	177,073	6.00	0	0.00
OFFICE SUPPORT ASST (KEYBRD)	76,922	3.53	129,950	5.01	107,729	5.00	0	0.00
SR OFC SUPPORT ASST (KEYBRD)	309,818	12.69	373,318	15.87	366,690	15.00	0	0.00
ACCOUNT CLERK II	138,038	5.52	129,183	5.00	125,087	5.00	0	0.00
AUDITOR II	116,860	3.25	290,234	9.12	143,807	4.00	0	0.00
AUDITOR I	138,676	4.17	34,423	1.00	164,721	5.00	0	0.00
SENIOR AUDITOR	269,873	6.70	278,355	7.00	279,985	7.00	0	0.00
AUDITOR III	38,504	0.71	67,524	1.00	0	0.00	0	0.00
ACCOUNTANT I	71,253	2.39	60,100	2.01	59,160	2.00	0	0.00
ACCOUNTANT III	160,446	3.78	173,712	4.00	164,099	4.00	0	0.00
PERSONNEL OFCR I	31,780	0.80	40,212	1.00	40,211	1.00	0	0.00
EXECUTIVE II	34,644	0.99	37,878	1.00	34,644	1.00	0	0.00
MANAGEMENT ANALYSIS SPEC II	245,417	5.56	225,331	4.86	219,240	5.00	0	0.00
HEALTH PROGRAM REP III	44,219	0.99	44,265	1.00	44,219	1.00	0	0.00
PHYSICIAN	109,524	0.99	109,524	1.00	109,525	1.00	0	0.00
REGISTERED NURSE II	9,543	0.26	0	0.00	0	0.00	0	0.00
REGISTERED NURSE III	86,692	1.93	13,325	0.38	0	0.00	0	0.00
REGISTERED NURSE IV	195,211	3.79	145,308	2.62	0	0.00	0	0.00
REGISTERED NURSE V	61,621	0.99	61,723	1.00	61,619	1.00	0	0.00
REGISTERED NURSE - CLIN OPERS	0	0.00	0	0.00	158,808	3.00	0	0.00
PHARMACEUTICAL CNSLT	0	0.00	394,067	3.00	0	0.00	0	0.00
PROGRAM DEVELOPMENT SPEC	393,930	9.59	381,299	10.00	411,508	10.00	0	0.00
INVESTIGATOR II	88,212	2.39	0	0.00	0	0.00	0	0.00
INVESTIGATOR III	0	0.00	15,264	0.00	0	0.00	0	0.00
MEDICAID PROGRAM RELATIONS REP	126,708	3.06	125,105	3.00	160,319	4.00	0	0.00
CORRESPONDENCE & INFO SPEC I	680,699	19.68	749,477	23.58	656,491	19.50	0	0.00
MEDICAID PHARMACEUTICAL TECH	207,826	6.59	207,535	6.58	216,671	7.00	0	0.00
MEDICAID CLERK	372,545	13.54	190,655	6.57	222,401	8.00	0	0.00
MEDICAID TECHNICIAN	856,076	27.32	867,746	28.87	913,565	28.54	0	0.00
MEDICAID SPEC	1,452,493	38.71	1,086,368	29.83	1,133,899	27.99	0	0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>MO HEALTHNET ADMIN</b>								
<b>CORE</b>								
MEDICAID UNIT SPV	666,186	15.34	533,311	11.00	531,270	11.00	0	0.00
FISCAL & ADMINISTRATIVE MGR B1	201,097	4.23	190,758	4.00	289,273	6.00	0	0.00
FISCAL & ADMINISTRATIVE MGR B2	174,802	2.85	184,374	3.00	249,258	4.00	0	0.00
RESEARCH MANAGER B1	53,291	0.99	53,291	1.00	53,290	1.00	0	0.00
SOCIAL SERVICES MGR, BAND 1	50,427	0.93	65,760	1.00	96,168	2.00	0	0.00
SOCIAL SERVICES MNGR, BAND 2	536,251	9.70	489,272	8.02	692,411	13.00	0	0.00
DESIGNATED PRINCIPAL ASST DEPT	39,030	0.49	0	0.00	0	0.00	0	0.00
DIVISION DIRECTOR	167,377	0.99	167,376	1.00	167,375	1.00	0	0.00
DEPUTY DIVISION DIRECTOR	170,907	1.52	82,102	1.00	89,000	1.00	0	0.00
DESIGNATED PRINCIPAL ASST DIV	164,800	2.03	82,092	1.00	91,613	1.08	0	0.00
LEGAL COUNSEL	71,569	0.99	71,562	1.00	71,568	1.00	0	0.00
MISCELLANEOUS TECHNICAL	0	0.00	39,911	1.41	0	0.00	0	0.00
MISCELLANEOUS PROFESSIONAL	13,158	0.14	0	0.00	0	0.00	0	0.00
SPECIAL ASST PROFESSIONAL	759,927	9.81	707,273	9.00	762,813	10.00	0	0.00
SPECIAL ASST OFFICE & CLERICAL	104,738	3.09	100,524	3.00	103,229	3.00	0	0.00
ASST TO BOARDS & COMMISSIONS	2,588	0.07	0	0.00	0	0.00	0	0.00
DEP DIR - BOARDS & COMMISSIONS	3,948	0.07	0	0.00	0	0.00	0	0.00
<b>TOTAL - PS</b>	<b>9,709,453</b>	<b>241.08</b>	<b>9,216,460</b>	<b>227.11</b>	<b>9,216,460</b>	<b>227.11</b>	<b>0</b>	<b>0.00</b>
TRAVEL, IN-STATE	33,993	0.00	11,054	0.00	34,000	0.00	0	0.00
TRAVEL, OUT-OF-STATE	8,232	0.00	5,317	0.00	5,300	0.00	0	0.00
SUPPLIES	477,027	0.00	438,005	0.00	485,429	0.00	0	0.00
PROFESSIONAL DEVELOPMENT	63,693	0.00	103,031	0.00	64,999	0.00	0	0.00
COMMUNICATION SERV & SUPP	89,367	0.00	99,702	0.00	90,000	0.00	0	0.00
PROFESSIONAL SERVICES	4,230,168	0.00	4,045,395	0.00	3,790,635	0.00	0	0.00
M&R SERVICES	263,196	0.00	38,561	0.00	265,000	0.00	0	0.00
COMPUTER EQUIPMENT	0	0.00	6,490	0.00	6,490	0.00	0	0.00
OFFICE EQUIPMENT	8,652	0.00	851	0.00	8,600	0.00	0	0.00
OTHER EQUIPMENT	2,227	0.00	1,240	0.00	2,240	0.00	0	0.00
PROPERTY & IMPROVEMENTS	6,241	0.00	0	0.00	6,241	0.00	0	0.00
BUILDING LEASE PAYMENTS	2,821	0.00	11,000	0.00	2,821	0.00	0	0.00
EQUIPMENT RENTALS & LEASES	1,949	0.00	2,844	0.00	1,949	0.00	0	0.00

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
MO HEALTHNET ADMIN								
CORE								
MISCELLANEOUS EXPENSES	4,521	0.00	4,735	0.00	4,521	0.00	0	0.00
TOTAL - EE	5,192,087	0.00	4,768,225	0.00	4,768,225	0.00	0	0.00
PROGRAM DISTRIBUTIONS	0	0.00	1,030	0.00	1,030	0.00	0	0.00
TOTAL - PD	0	0.00	1,030	0.00	1,030	0.00	0	0.00
GRAND TOTAL	\$14,901,540	241.08	\$13,985,715	227.11	\$13,985,715	227.11	\$0	0.00
GENERAL REVENUE	\$4,236,363	78.84	\$3,473,535	64.53	\$3,473,535	64.53		0.00
FEDERAL FUNDS	\$8,667,666	127.10	\$8,284,283	118.49	\$8,284,283	118.49		0.00
OTHER FUNDS	\$1,997,511	35.14	\$2,227,897	44.09	\$2,227,897	44.09		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: MO HealthNet Administration**

**Program is found in the following core budget(s): MO HealthNet Administration**

### 1. What does this program do?

In order to efficiently operate the \$7 billion MO HealthNet program, the MO HealthNet Division effectively utilizes its appropriated staff of 227.11 FTE. Without these staff and expense and equipment resources, the MO HealthNet program would not function. The staff running the MO HealthNet program account for less than .4% of total state employees while the MO HealthNet program comprises 30% of the total FY 2012 state operating budget of \$23.1 billion. The Administrative portion of the budget (Personal Services and Expense and Equipment) comprises less than 0.2% of the division's total budget. As of June 2011, there were a total of 897,306 participants enrolled in MO HealthNet for a ratio of 3,951 clients per FTE. Participants and providers benefit from the assistance of the MO HealthNet Division's staff.

Administrative expenditures for the division consist of Personal Services and Expense and Equipment. These expenditures are driven by the operational demands of the MO HealthNet program. The division operates both a fee-for-service program and a managed care program. As of June 2011, there were 446,703 participants eligible for capitated managed care in the Eastern, Central and Western regions of the state. At the same time, fee-for-service programs with 450,603 MO HealthNet participants are being operated for those not in managed care. Administrative expenditures also include payment to contractors for professional services comprising about 84% of the administrative Expense & Equipment expenditures. Examples of professional services include consulting contracts with health care professionals to conduct utilization claim reviews to determine medical necessity of services. Other examples of contracted services include actuarial services and services of an external quality reviewer as required by federal law.

The remaining 16% of administrative Expense and Equipment expenditures goes to support MO HealthNet employees for such needs as supplies, postage, and office equipment. MO HealthNet administration is tightly managed with a primary focus of ensuring that expenditures go to benefit program participants to ensure participants receive needed medical services. MO HealthNet staff also support the MMAC unit in their efforts to protect against waste, fraud and abuse of program dollars.

Personal Services The Division is structured into four major sections: (1) Finance (2) Program Operations (3) Medical Services and (4) Information Services. The Finance section incorporates the newest and best technology to accurately and efficiently pay providers in a paperless environment. Technology provides a robust reporting function that is a critical part of the management responsibility of the agency. The Finance Section consists of the following programs and duties: Financial Services and Reporting; Waiver Financing and Rate Setting; Institutional Reimbursement; Financial Reports and Budget; Pharmacy Fiscal; Cost Recovery and Audit Services; and MMAC liaison.

The Program Operations section allows for policy decisions and processes to be oriented to the health and continuum of care needed by participants. Program Operations consists of the following programs and duties: Managed Care Contract and Operations; Clinical Program Development; Program Relations, Participant Services, and Provider Education; Federal Waiver Programs; Pharmacy Clinical and Exceptions; MO Rx; CHIP; NEMT; PACE; and Personnel Liaison.

The Medical Services section is responsible for ensuring that quality medical care is provided to participants. The Medical Services Section, led by the division's Medical Director, consists of the following programs and duties: Physicians and Clinics; Quality Section - Managed Care and Fee For Service; Psychology Program; Patient Centered Medical Homes; and Evidenced Based Clinical Decision Development and Support.

The Information Services section is responsible for the tools and data needed to support MHD decision making and claims processing. The Information Services section consists of the following programs and duties: MMIS; Medicaid Research; Decision Support; Medicaid HIE/HIT; Project Management of ICD-10 and 5010; ACS Contract; Interdepartmental IS/IT Systems Integration; Clinical Services Technical Support; and Liaison with the State HIT Coordinator. The following provides a brief description of the agency's structure.

## Administration

- **Administration** - Establishes goals, objectives, policies, and procedures; overall guidance and direction; legislative guidance on MO HealthNet issues; and final review of the budget and State Plan Amendments.

## Finance

- **Financial Services and Reporting** - Manages the financial procedures of the division; creates internal expenditure reports; prepares adjustments to claims; receives and deposits payments; manages provider account receivables and 1099 information; and manages lock box, automatic withdrawals and cash deposits for CHIP and spenddown pay-in cases.
- **Waiver Financing and Rate Setting** - Develops capitation rates with actuary for Managed Care Program, NEMT and PACE. Prepares federal budget neutrality reports.
- **Institutional Reimbursement** - Calculates hospital inpatient and outpatient rates and FQHC/RHC reimbursements; sets nursing home reimbursement rates; and administers hospital, nursing facility and ICF/MR provider taxes.
- **Financial Reporting and Budget** - Develops and tracks the division's annual budget request; prepares fiscal notes and program projections; prepares quarterly estimates and expenditure reports required by CMS; prepares legislative bill reviews; and processes accounts payable for the division.
- **Pharmacy Fiscal** - Develops and tracks the Pharmacy budget; prepares fiscal notes, legislative bill reviews and projections for the Pharmacy program; and administers the pharmacy tax.
- **Cost Recovery and Audit Services** - Administers a program to offset MO HealthNet expenditures when participants have third party coverage; MMAC liaison; and provides audit support.

## Program Operations

- **Managed Care** - Contract compliance, development and operations of the Managed Care Program.
- **Clinical Program Development** - Develops, monitors and evaluates various MO HealthNet benefit programs.
- **Program Relations** - Responsible for provider education, provider communications, participant services and premium collections.
- **Waivers** - Develops, monitors and evaluates Federal Waiver programs.
- **Pharmacy** - Oversees outpatient prescription drug reimbursement for Fee-For-Service eligibles; operates a toll-free hotline; oversight of contracts with outside vendors for pharmacy program enhancement activities; collects rebates from pharmaceutical manufacturers; coordinates pharmaceutical benefits for the Medicare Part D program.

## Medical Services

- **Medical Services** - Develops strategies to improve the health status of MO HealthNet participants; assess quality of care provided under Managed Care and Fee-For-Service; evidence based clinical decision development and support; and patient centered medical home management.

## Information Services

- **Information Services** - Payment system and MMIS - oversees and monitors the information system contracts, ACS contract and clinical management services and system for pharmacy and prior authorization contracts.



### Expense and Equipment

The other major category in the Administration Core besides Personal Services is Expense and Equipment (E&E). In the FY 2011 core, it comprises 35% of the total Administration Core of \$16.4 million, or approximately \$5.8 million. Contracts for professional services total \$4.6 million of the division's Expenses and Equipment (E&E).

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.201; Federal law: Social Security Act Section 1902(a)(4); Federal Regulations: 42 CFR, Part 432

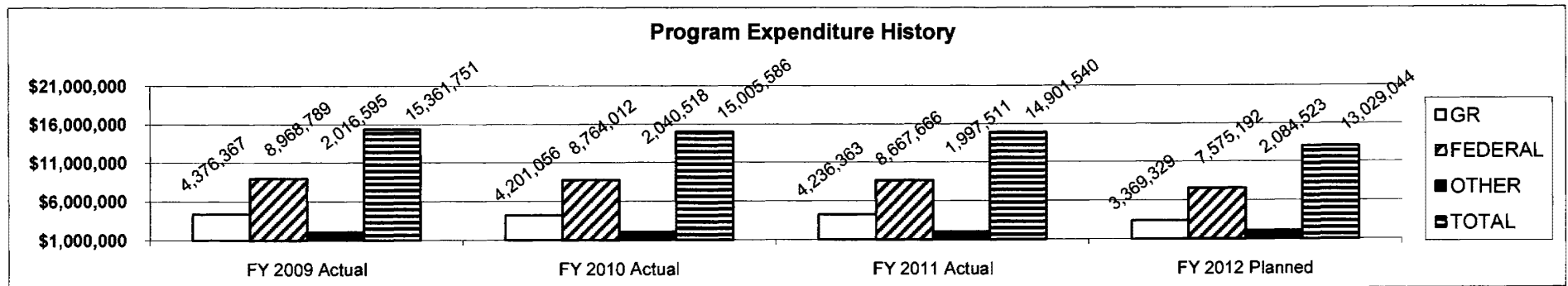
### 3. Are there federal matching requirements? If yes, please explain.

Medicaid administrative expenditures earn a 50% federal match. However, some positions earn 75% federal match such as our medical staff, pharmacy exceptions hotline, etc. Some contracted vendors earn 75% and 90% federal match.

### 4. Is this a federally mandated program? If yes, please explain.

Yes. Section 1902 (a) (4) of the Social Security Act requires such methods of administration as necessary for the proper and efficient administration of the MO HealthNet State Plan.

### 5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



**6. What are the sources of the "Other " funds?**

Federal Reimbursement Allowance Fund (0142), Third Party Liability Collections Fund (0120), Nursing Facility Quality of Care Fund (0271), Health Initiatives Fund (0275), Pharmacy Reimbursement Allowance Fund (0144), Missouri Rx Plan Fund (0779) and Ambulance Service Reimbursement Allowance Fund (0958).

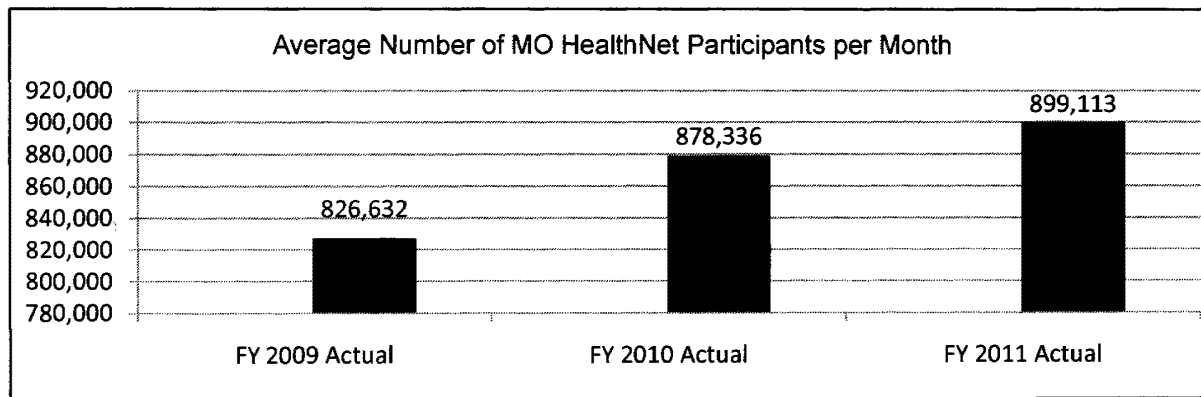
**7a. Provide an effectiveness measure.**

MO HealthNet Administration supports all division programs. Effectiveness measures can be found in Program sections.

**7b. Provide an efficiency measure.**

MO HealthNet Administration supports all division programs. Efficiency measures can be found in the Program sections.

**7c. Provide the number of clients/individuals served, if applicable.**



**7d. Provide a customer satisfaction measure, if available.**

# **Clinical Services Program Management**

# FY13 Department of Social Service Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
CLINICAL SRVC MGMT								
CORE								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	468,656	0.00	483,913	0.00	483,913	0.00	0	0.00
DEPT OF SOC SERV FEDERAL & OTH	10,940,092	0.00	12,215,288	0.00	12,215,288	0.00	0	0.00
THIRD PARTY LIABILITY COLLECT	876,136	0.00	924,911	0.00	924,911	0.00	0	0.00
HEALTH CARE TECHNOLOGY FUND	2,149,966	0.00	0	0.00	0	0.00	0	0.00
MISSOURI RX PLAN FUND	706,892	0.00	4,160,894	0.00	4,160,894	0.00	0	0.00
TOTAL - EE	15,141,742	0.00	17,785,006	0.00	17,785,006	0.00	0	0.00
TOTAL	15,141,742	0.00	17,785,006	0.00	17,785,006	0.00	0	0.00
Sustain MHD Tech Infrastructur - 1886015								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	0	0.00	0	0.00	2,187,500	0.00	0	0.00
TOTAL - EE	0	0.00	0	0.00	2,187,500	0.00	0	0.00
TOTAL	0	0.00	0	0.00	2,187,500	0.00	0	0.00
GRAND TOTAL	\$15,141,742	0.00	\$17,785,006	0.00	\$19,972,506	0.00	\$0	0.00

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Clinical Services Program Management

Budget Unit: 90516C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE	483,913	12,215,288	5,085,805	17,785,006
PSD				
TRF				
Total	483,913	12,215,288	5,085,805	17,785,006
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Third Party Liability Collections (TPL) (0120)  
MO Rx Plan Fund (0779)

## 2. CORE DESCRIPTION

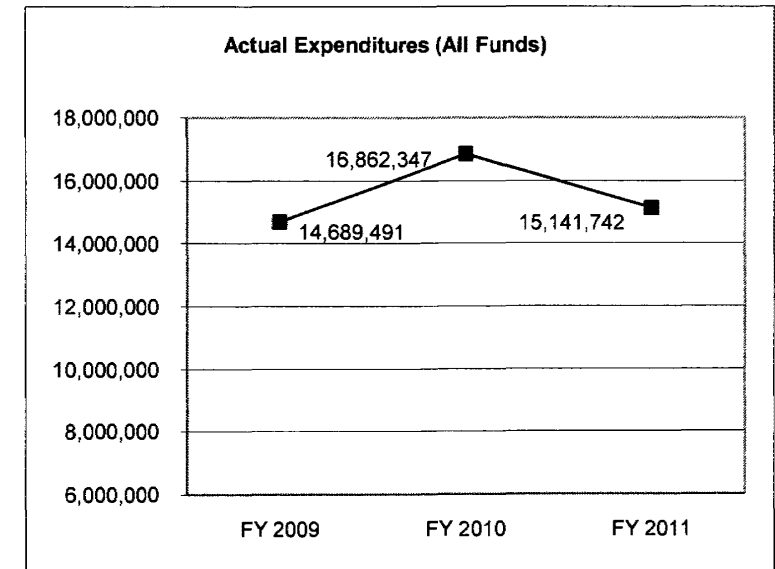
This core request is for the contractor costs that support the Pharmacy and Clinical Services programs. Funding is used for cost containment initiatives and clinical policy decision-making to enhance efforts to provide appropriate and quality medical care to participants. MO HealthNet Division seeks to aid recipients and providers in their efforts to access the MO HealthNet program by utilizing contractor resources effectively.

## 3. PROGRAM LISTING (list programs included in this core funding)

Missouri Medicaid Pharmacy Enhancement Program  
Missouri Rx Program

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	17,839,716	20,039,716	19,974,091	17,785,006
Less Reverted (All Funds)	(69,034)	(82,159)	(15,725)	N/A
Budget Authority (All Funds)	17,770,682	19,957,557	19,958,366	N/A
Actual Expenditures (All Funds)	14,689,491	16,862,347	15,141,742	N/A
Unexpended (All Funds)	3,081,191	3,095,210	4,816,624	N/A
Unexpended, by Fund:				
General Revenue	10,899	2,611	1,117	N/A
Federal	78,897	97,920	1,275,196	N/A
Other	2,991,395	2,994,679	3,540,311	N/A
	(1)(2)	(3)(4)	(5)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

(1) Agency reserve of \$78,896 in Federal and \$10,899 in General Revenue.

(2) FY2009 Increases: Transfer \$3.75 million from Health Care Technology section to support CyberAccess. Additional \$2.5 million for electronic prior authorization of DME.

(3) FY 2010 Increase: \$2.5 million to integrate hospital pre-certification with CyberAccess.

(4) Agency reserve of \$2,674,172; \$1,865 GR, \$72,307 in Federal and \$2,600,000 in MO Rx Plan funds.

(5) Agency reserve of \$2,733,621; \$133,621 in Federal and \$2,600,000 in MO Rx Plan funds.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES**  
**CLINICAL SRVC MGMT**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	EE	0.00	483,913	12,215,288	5,085,805	17,785,006	
	<b>Total</b>	<b>0.00</b>	<b>483,913</b>	<b>12,215,288</b>	<b>5,085,805</b>	<b>17,785,006</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	EE	0.00	483,913	12,215,288	5,085,805	17,785,006	
	<b>Total</b>	<b>0.00</b>	<b>483,913</b>	<b>12,215,288</b>	<b>5,085,805</b>	<b>17,785,006</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	EE	0.00	483,913	12,215,288	5,085,805	17,785,006	
	<b>Total</b>	<b>0.00</b>	<b>483,913</b>	<b>12,215,288</b>	<b>5,085,805</b>	<b>17,785,006</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
CLINICAL SRVC MGMT								
CORE								
TRAVEL, IN-STATE	11,436	0.00	15,115	0.00	15,115	0.00	0	0.00
TRAVEL, OUT-OF-STATE	5,866	0.00	4,100	0.00	4,100	0.00	0	0.00
SUPPLIES	366,044	0.00	397,100	0.00	397,100	0.00	0	0.00
PROFESSIONAL DEVELOPMENT	2,812	0.00	1,000	0.00	1,000	0.00	0	0.00
COMMUNICATION SERV & SUPP	71,183	0.00	70,600	0.00	70,600	0.00	0	0.00
PROFESSIONAL SERVICES	14,636,503	0.00	17,242,641	0.00	17,242,641	0.00	0	0.00
M&R SERVICES	28,073	0.00	25,000	0.00	25,000	0.00	0	0.00
OTHER EQUIPMENT	104	0.00	7,000	0.00	7,000	0.00	0	0.00
PROPERTY & IMPROVEMENTS	0	0.00	250	0.00	250	0.00	0	0.00
BUILDING LEASE PAYMENTS	17,083	0.00	15,500	0.00	15,500	0.00	0	0.00
MISCELLANEOUS EXPENSES	2,638	0.00	6,700	0.00	6,700	0.00	0	0.00
TOTAL - EE	15,141,742	0.00	17,785,006	0.00	17,785,006	0.00	0	0.00
GRAND TOTAL	\$15,141,742	0.00	\$17,785,006	0.00	\$17,785,006	0.00	\$0	0.00
GENERAL REVENUE	\$468,656	0.00	\$483,913	0.00	\$483,913	0.00		0.00
FEDERAL FUNDS	\$10,940,092	0.00	\$12,215,288	0.00	\$12,215,288	0.00		0.00
OTHER FUNDS	\$3,732,994	0.00	\$5,085,805	0.00	\$5,085,805	0.00		0.00



## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Clinical Services Program Management**

**Program is found in the following core budget(s): Clinical Services Program Management**

### 1. What does this program do?

*PROGRAM SYNOPSIS: The funding for Clinical Services Management supports the Pharmacy and Clinical Services' contractor costs.*

#### Pharmacy

Through the Pharmacy Program, the Division is able to maintain current cost containment initiatives and implement new cost containment initiatives. Major initiatives include:

- Help Desk Staffing
- Quarterly Updates to the Missouri Maximum Allowable Cost (MACs)
- Maintenance and Updates to Fiscal and Clinical Edits
- Prospective and Retrospective Drug Use Review (DUR)
- Routine/Adhoc Drug Information Research
- Enrollment and Administration of Case Management
- Preferred Drug List (PDL) and Supplemental Rebates

These initiatives, along with other cost containment activities, have resulted in an increase in the pharmacy cost that is significantly below the national trend over the past few years.

#### Clinical

The major initiatives in the Clinical Services section include:

- Psychology and Medical Help Desk Staffing
- Smart PA for DME, including Dental and Optometry
- Major Medical PA, including Imaging
- Medical Evidence - Oregon Contract

#### Cyber Access

CyberAccess is an Electronic Health Record (EHR) program for MO HealthNet participants which is available to their healthcare providers. The Web-based tool, called CyberAccess, allows physicians to prescribe electronically, view diagnosis data, receive alerts, select appropriate preferred medications, and electronically request drug and medical prior authorizations for their MO HealthNet patients. The continued funding for CyberAccess is critical to continue to support the pharmacy and medical cost containment initiatives and electronic health records. EPSDT forms and patient specific lab results are currently available. Linkages to other health record systems yielding interoperability between systems will soon be available as well. A companion participant web portal tool is being developed.

The section is responsible for program development and clinical policy decision-making for MO HealthNet, with these activities oriented to the health and continuum of care needed by MO HealthNet participants. Policy development, benefit design and coverage decisions are made by the unit using best practices and evidence-based medicine.

In July 2010, the MO HealthNet Division (MHD), in conjunction with Affiliated Computer Services (ACS) and MedSolutions (MSI), implemented a new quality-based Radiology Benefit Management Program (RBM). The RBM is an expansion of the existing pre-certification process currently being used for MRIs and CTs of the brain, head, chest and spine. The RBM works to determine clinical appropriateness of the usage of high-tech radiology services, and provides guidelines for application and use based on expert information and evidence-based data. Pre-certification requests are handled using robust clinical guidelines. These guidelines will be used to ensure the appropriate scope, complexity and clinical need of the tests that will be performed.

The MHD and Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS) are in the final stages of completing a single integrated web-based instrument for entering, tracking and approving Home and Community Based Services (HCBS) requests and follow-up data. The new electronic tool (a component of CyberAccess) will allow more consistent service authorization and delivery to clients with varying needs. The tool will be based on a real-time interface with paid Medicaid claims data to allow automated and transparent processing of requests for services. All HCBS clients will be assessed for services using the same tool, employing a rules-based engine to establish the client's level of care based on the need. The current points-based system will be translated into algorithms whereby responses to requested information will automatically calculate a point score and generate a service plan.

MHD is in the process of implementing additional fiscal and clinical integrity edits to enable providers to submit and receive prior authorization determinations for home health services, certain physician services, and miscellaneous laboratory services. The algorithms for home health services will assure the appropriate level and quantity of services to allow the participant to remain in the least restrictive setting, while also avoiding unnecessary inpatient hospitalizations or skilled nursing home costs. The algorithms will be incorporated into the provider request portal and the Smart PA rules engine and will be based on standard criteria, including Milliman Care Guidelines, Reed Group MDGuidelines, and Official Disability Guidelines.

**2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State statute: RSMo. 208.201; Federal law: Social Security Act Section 1902(a)(4); Federal Regulations: 42 CFR, Part 432

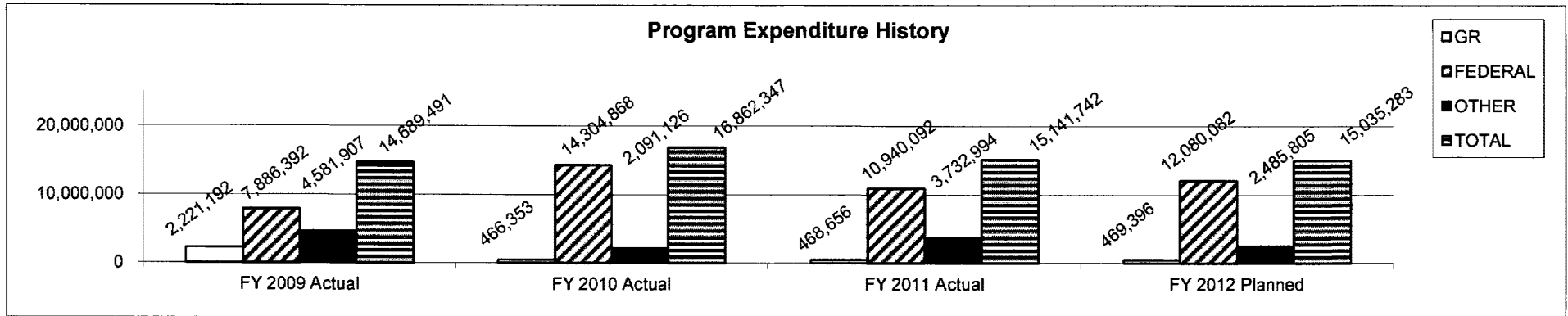
**3. Are there federal matching requirements? If yes, please explain.**

MO HealthNet administrative expenditures earn a 50% federal match. The Clinical Management Services for Pharmacy and Prior Authorization is matched at 75%.

**4. Is this a federally mandated program? If yes, please explain.**

Yes. Section 1902 (a) (4) of the Social Security Act requires such methods of administration as necessary for the proper and efficient administration of the Medicaid State Plan.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



Reverted: \$14,517 GR

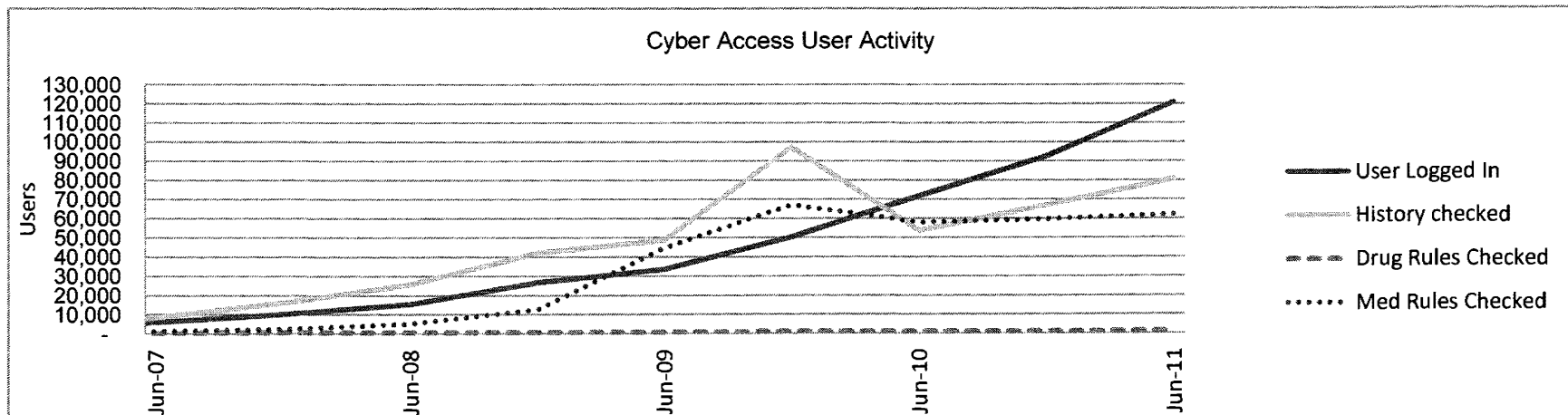
Reserve: \$2,735,206 Federal and Other Funds

**6. What are the sources of the "Other " funds?**

FY 2009-FY 2011: Third Party Liability Collections Fund (0120), Health Care Technology (0170) and Missouri Rx Plan Fund (0779).

FY 2012: Third Party Liability Fund (0120) and Missouri Rx Plan Fund (0779)

**7a. Provide an effectiveness measure.**



User activity is projected to grow consistent with historical trends.

**7b. Provide an efficiency measure.**

**7c. Provide the number of clients/individuals served, if applicable.**

Number of Pharmacy Claims		
SFY	Actual	Projected
2009	9.3 mil	
2010	12.0 mil	
2011	12.9 mil	
2012		13.5 mil
2013		14.2 mil
2014		14.9 mil

*Source: MMIS Pharmacy Reimbursement Allowance Report*

**7d. Provide a customer satisfaction measure, if available.**

# **Women and Minority Health Care Outreach**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>WOMEN &amp; MINORITY OUTREACH</b>								
<b>CORE</b>								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	529,741	0.00	546,125	0.00	546,125	0.00	0	0.00
DEPT OF SOC SERV FEDERAL & OTH	568,625	0.00	568,625	0.00	568,625	0.00	0	0.00
TOTAL - EE	1,098,366	0.00	1,114,750	0.00	1,114,750	0.00	0	0.00
<b>TOTAL</b>	<b>1,098,366</b>	<b>0.00</b>	<b>1,114,750</b>	<b>0.00</b>	<b>1,114,750</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$1,098,366</b>	<b>0.00</b>	<b>\$1,114,750</b>	<b>0.00</b>	<b>\$1,114,750</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

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# CORE DECISION ITEM

Department: Social Services  
 Division: MO HealthNet  
 Core: Women & Minority Health Care Outreach

Budget Unit: 90513C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE	546,125	568,625		1,114,750
PSD				
TRF				
Total	546,125	568,625		1,114,750
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

## 2. CORE DESCRIPTION

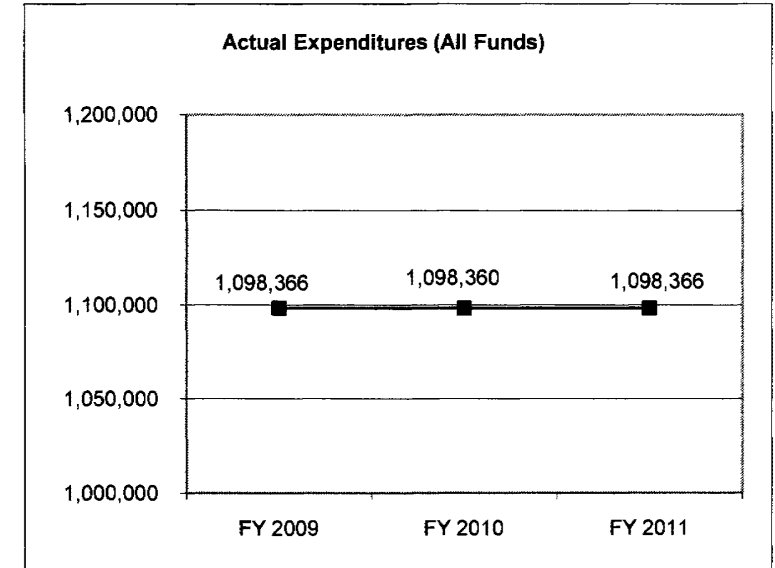
This core request is for the continued funding of the Women and Minority Health Care Outreach programs. These programs provide client outreach and education about the MO HealthNet program and reduce disparities in healthcare access for women and minority populations.

## 3. PROGRAM LISTING (list programs included in this core funding)

Women and Minority Health Care Outreach Program

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	1,114,750	1,114,750	1,114,750	1,114,750
Less Reverted (All Funds)	(16,384)	(16,384)	(16,384)	N/A
Budget Authority (All Funds)	1,098,366	1,098,366	1,098,366	N/A
Actual Expenditures (All Funds)	1,098,366	1,098,360	1,098,366	N/A
Unexpended (All Funds)	0	6	0	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	0	6	0	N/A
Other	0	0	0	N/A



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.



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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES****WOMEN & MINORITY OUTREACH**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>	EE	0.00	546,125	568,625	0	1,114,750	
	<b>Total</b>	<b>0.00</b>	<b>546,125</b>	<b>568,625</b>	<b>0</b>	<b>1,114,750</b>	
<b>DEPARTMENT CORE REQUEST</b>	EE	0.00	546,125	568,625	0	1,114,750	
	<b>Total</b>	<b>0.00</b>	<b>546,125</b>	<b>568,625</b>	<b>0</b>	<b>1,114,750</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>	EE	0.00	546,125	568,625	0	1,114,750	
	<b>Total</b>	<b>0.00</b>	<b>546,125</b>	<b>568,625</b>	<b>0</b>	<b>1,114,750</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>WOMEN &amp; MINORITY OUTREACH</b>								
<b>CORE</b>								
PROFESSIONAL SERVICES	1,098,366	0.00	1,114,750	0.00	1,114,750	0.00	0	0.00
TOTAL - EE	1,098,366	0.00	1,114,750	0.00	1,114,750	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$1,098,366</b>	<b>0.00</b>	<b>\$1,114,750</b>	<b>0.00</b>	<b>\$1,114,750</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$529,741	0.00	\$546,125	0.00	\$546,125	0.00		0.00
FEDERAL FUNDS	\$568,625	0.00	\$568,625	0.00	\$568,625	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Women and Minority Health Care Outreach**

**Program is found in the following core budget(s): Women and Minority Health Care Outreach**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides client outreach and education about the MO HealthNet program with a goal to reduce disparities in health care access for women and minority populations.*

The health of Missouri's citizens is critical to the well-being of the state. Without proper health care, Missouri citizens will be less productive and more costly to the state. The purpose of the MO HealthNet program is to finance, monitor and assure the health coverage of traditionally vulnerable populations. The funding in this appropriation provides outreach services in St. Louis, Columbia, Jefferson City, Springfield, the Bootheel, and the Kansas City Region targeted at African-American men and women at risk of diabetes, cardiovascular disease, HIV/AIDS, sexually transmitted diseases (STDs), and other life-threatening health conditions. The outreach programs also provide client outreach and education about the MO HealthNet program.

The Department of Social Services has contracted with the Missouri Primary Care Association to act as a fiscal intermediary for the distribution of the Minority and Women's Health Outreach funding, assuring accurate and timely payments to the subcontractors and to act as a central data collection point for evaluation of program impact and outcomes. The Missouri Primary Care Association is recognized as Missouri's single primary care association by the federal Health Resource Service Administration. The goals of the nation's Primary Care Associations are to partner in the development, maintenance and improvement of access to health care services, and to reduce disparities in health status between majority and minority populations.

This program was initiated in the fall of 1999 with five Federally-Qualified Health Centers (FQHCs) and has now expanded to twelve FQHCs in the St Louis, Kansas City, mid-Missouri, Southwest, and Bootheel regions. The outreach program builds on the strengths of the twelve FQHCs that are trusted, accessible sources of care for high-risk African-American populations, and the existence of natural leaders, often women, in African-American neighborhoods to provide outreach and education in their neighborhoods to encourage routine screenings for diabetes and cardiovascular disease and testing for HIV/AIDS and STDs. In the Bootheel area, the outreach program builds on the strengths of a FQHC and county hospital, using the Care-A-Van to reach at-risk persons in the largely rural area. Existing health promotion coalitions in the area, including the Bootheel's Heart Health Coalitions and the Missouri Health Alliance will also be used in outreach efforts. As part of the outreach program, workers identify eligible participants and help them enroll in the MO HealthNet program.

The current contractor is Missouri Primary Care Association. The contractor is paid for allowable costs related to establishing and implementing outreach programs not to exceed the appropriation cap.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, 208.201; Federal law: Social Security Act Section 1903(a); Federal Regulations: 42 CFR, Part 433.15

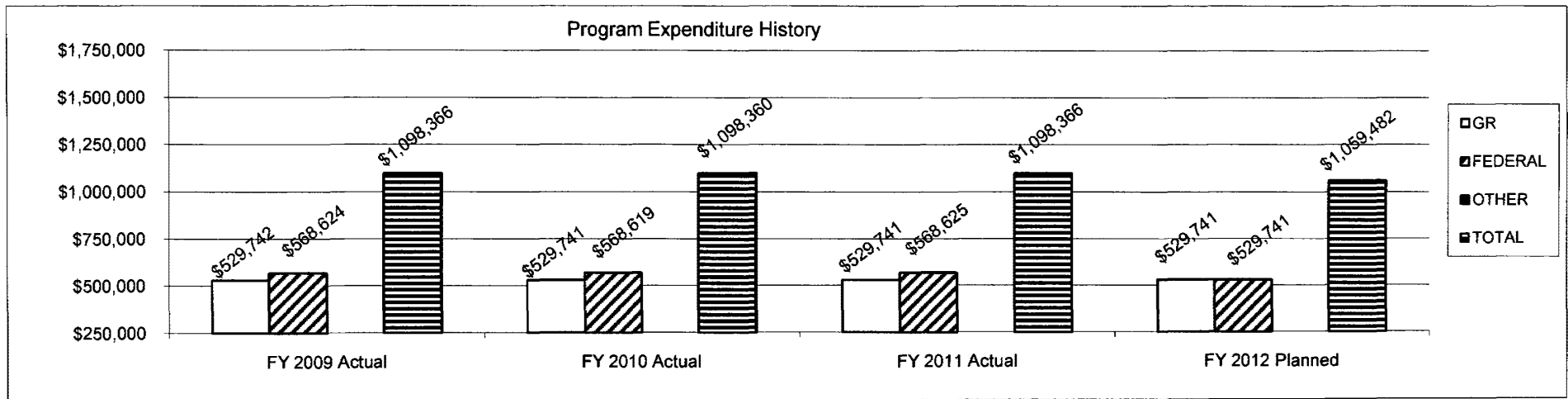
### 3. Are there federal matching requirements? If yes, please explain.

Medicaid administrative expenditures earn a 50% federal match. For every dollar spent, DSS can earn \$0.50 in federal funding.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



FY12 Reverted: \$16,384 General Revenue

FY 12 Reserve: \$38,884 Federal Funds

6. What are the sources of the "Other" funds?

N/A

7a. Provide an effectiveness measure.

**7b. Provide an efficiency measure.**

FQHCs and RHCs in underserved areas provide greater access to health care services for women and minorities as well as serve as outreach centers to assist individuals in applying for MO HealthNet services.

Number of Users of FQHCs and RHCs for Primary Care		
SFY	Actual	Projected
2009	93,142	
2010	109,887	
2011	131,011	
2012		152,000
2013		173,000
2014		194,000

Number of Users Receiving Assistance from FQHCs and RHCs in Applying for MO HealthNet		
SFY	Actual	Projected
2009	6,160	
2010	8,872	
2011	14,719	
2012		20,500
2013		26,300
2014		32,100

**7c. Provide the number of clients/individuals served, if applicable.**

Prenatal Care Users Who Delivered During the Year		
SFY	Actual	Projected
2009	3,465	
2010	4,191	
2011	4,277	
2012		4,360
2013		4,445
2014		4,530

Number of Normal Births		
SFY	Actual	Projected
2009	3,186	
2010	3,842	
2011	3,883	
2012		3,920
2013		3,960
2014		4,000

Services are directed toward low-income women and minorities who are uninsured or eligible for MO HealthNet.

**7d. Provide a customer satisfaction measure, if available.**

# **TPL Contracts**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
TPL CONTRACTS								
CORE								
EXPENSE & EQUIPMENT								
DEPT OF SOC SERV FEDERAL & OTH	2,261,861	0.00	1,500,000	0.00	1,500,000	0.00	0	0.00
THIRD PARTY LIABILITY COLLECT	2,261,860	0.00	1,500,000	0.00	1,500,000	0.00	0	0.00
TOTAL - EE	4,523,721	0.00	3,000,000	0.00	3,000,000	0.00	0	0.00
TOTAL	4,523,721	0.00	3,000,000	0.00	3,000,000	0.00	0	0.00
GRAND TOTAL	\$4,523,721	0.00	\$3,000,000	0.00	\$3,000,000	0.00	\$0	0.00

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Third Party Liability (TPL) Contracts

Budget Unit: 90515C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE		1,500,000	1,500,000	3,000,000
PSD				
TRF				
Total		1,500,000	1,500,000	3,000,000
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Third Party Liability Collections Fund (TPL) (0120)

Note: An "E" is requested for \$1,500,000 Other Funds and \$1,500,000 Federal Funds.

## 2. CORE DESCRIPTION

This core request is for the continued funding of contracted third party liability (TPL) recovery activities. TPL functions are performed by agency staff in the TPL Unit and by a contractor. This core appropriation is Expense and Equipment funding and is the source of payments to the contractor who works with the agency on TPL recovery activities.

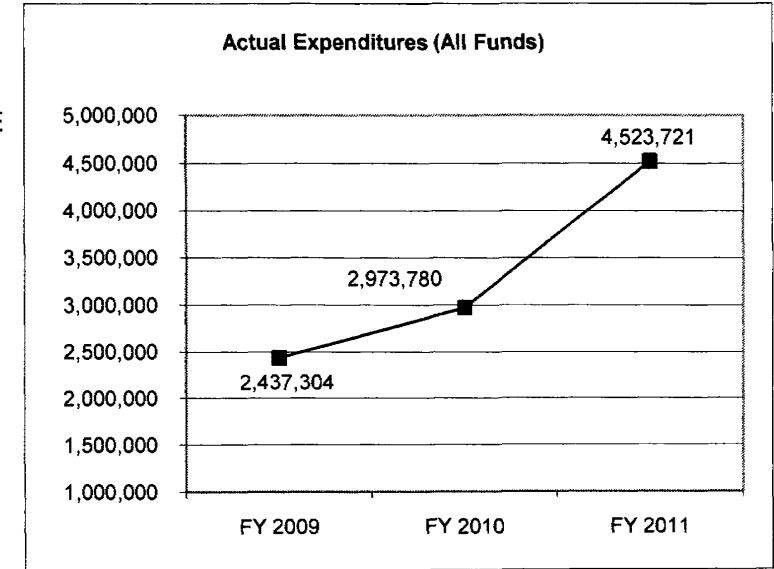
## 3. PROGRAM LISTING (list programs included in this core funding)

Third Party Liability Contracts



#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	6,000,000	3,000,000	4,523,722	3,000,000 E
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	6,000,000	3,000,000	4,523,722	N/A
Actual Expenditures (All Funds)	2,437,304	2,973,780	4,523,721	N/A
Unexpended (All Funds)	3,562,696	26,220	1	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	1,781,348	13,110	0	N/A
Other	1,781,348	13,110	1	N/A
	(1)	(2) (3)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

Estimated "E" appropriation for federal and Third Party Liability Collections (TPL) fund appropriations.

(1) Agency reserves of \$2,900,000 in E & E: \$1,450,000 in federal and \$1,450,000 in TPL fund.

(2) FY2010 core reduction of \$3.0 million for empty authority.

(3) Agency reserves of \$13,105 in federal and \$13,105 in TPL fund appropriations.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES****TPL CONTRACTS**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>	EE	0.00	0	1,500,000	1,500,000	3,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>1,500,000</b>	<b>1,500,000</b>	<b>3,000,000</b>	
<b>DEPARTMENT CORE REQUEST</b>	EE	0.00	0	1,500,000	1,500,000	3,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>1,500,000</b>	<b>1,500,000</b>	<b>3,000,000</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>	EE	0.00	0	1,500,000	1,500,000	3,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>1,500,000</b>	<b>1,500,000</b>	<b>3,000,000</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
TPL CONTRACTS								
CORE								
PROFESSIONAL SERVICES	4,523,721	0.00	3,000,000	0.00	3,000,000	0.00	0	0.00
TOTAL - EE	4,523,721	0.00	3,000,000	0.00	3,000,000	0.00	0	0.00
GRAND TOTAL	\$4,523,721	0.00	\$3,000,000	0.00	\$3,000,000	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$2,261,861	0.00	\$1,500,000	0.00	\$1,500,000	0.00		0.00
OTHER FUNDS	\$2,261,860	0.00	\$1,500,000	0.00	\$1,500,000	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Third Party Liability (TPL) Contracts**

**Program is found in the following core budget(s): Third Party Liability (TPL) Contracts**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides payments for contracted TPL recovery activities. By identifying other insurance carriers, MO HealthNet is able to cost avoid or recover costs already incurred.*

The Third Party Liability (TPL) program is responsible for cost recovery and cost avoidance of MO HealthNet expenditures. The MO HealthNet program seeks recovery from third-party sources when liability at the time of service had not yet been determined, when the third-party source was not known at the time of MO HealthNet payment, and for services that are federally mandated to be paid and then pursued. TPL functions are performed by agency staff in the TPL Unit and by a contractor. The TPL Contracts appropriation allows for payment to the contractor who works with the agency on TPL recovery and cost avoidance activities. The contractor is paid for its recovery services through a 10% contingency contract rate for cash recoveries and on a per member per month (PMPM) rate of \$.15 for the cost avoidance services. The TPL program accounted for more than \$230.2 million in savings for the MO HealthNet program in FY 11 by cost avoiding claims and recovering MO HealthNet funds. Health Plans in the MO HealthNet Managed Care program are responsible for the TPL activities related to plan enrollees.

Historically, the contractor is successful in areas of recovery that the state is unable to pursue due to staff and computer system limitations, for instance, in Health Insurance Recovery. When the retroactive cash recovery benefit is exhausted, these recovery areas are converted to cost avoidance mechanisms and transferred to the state MMIS claims processing system. The contractor has the advantage of automation to increase TPL recoveries. Information stored in the data base includes participant eligibility, insurance carrier, billing addresses, insurance coverage, and other reference information necessary for automated billing. The TPL Unit and the contractor share responsibility for maintaining and updating the data, as well as conducting manual operations that continue to be a part of the recovery program.

Even though some responsibilities are shared, the TPL Unit and the contractor each perform specific cost saving and recovery activities. The TPL Unit concentrates on asserting liens on settlements of trauma-related incidents (which include personal injury, product liability, wrongful death, malpractice, workers' compensation, and traffic accidents). The TPL Unit also files claims for recovery of MO HealthNet expenditures in estate cases, TEFRA cases, on the personal funds accounts of deceased nursing home residents, and on any excess funds from irrevocable burial plans. For cost avoidance, the TPL Unit operates the Health Insurance Premium Payment (HIPP) Program and maintains the TPL data base where participant insurance information is stored. The contractor focuses on bulk billings to insurance carriers and other third parties and data matches to identify potential third parties. The following list itemizes the activities performed by the contractor as compared to those performed by the TPL Unit staff, and is followed by descriptions of the primary TPL programs.

#### TASKS PERFORMED BY THE CONTRACTOR

- ✓ Health insurance billing and follow-up;
- ✓ Data matches and associated billing (Tricare, MCHCP, and other insurance carriers such as BCBS, United Healthcare and Aetna);
- ✓ Provide TPL information for state files;
- ✓ Post Accounts Receivable data to state A/R system; and
- ✓ Maintain insurance billing files.

The current contractor is Health Management Systems (HMS). The contractor is paid for services on a contingency basis for recovery activities and a PMPM basis for cost avoidance activities through a portion of cash recoveries.

#### TASKS PERFORMED BY STATE TPL STAFF

- ✓ Liens, updates and follow-up on Trauma cases;
- ✓ Identify and follow-up on all Estate cases;
- ✓ Identify, file and follow-up on TEFRA liens;
- ✓ Identify and follow-up on Personal Funds cases;
- ✓ Recover any excess funds from irrevocable burial plans;
- ✓ Operate HIPPP program;
- ✓ Post recoveries to Accounts Receivable systems;
- ✓ Maintain state TPL databases;
- ✓ Verify leads through MMIS contract; and
- ✓ Contract oversight.

HIPPP Program - The objective of the Health Insurance Premium Payment Program (HIPPP) is to identify and pay for employer-sponsored insurance policies for MO HealthNet participants to maximize MO HealthNet monies by shifting medical costs to private insurers and exhausting all third party resources before utilizing MO HealthNet. Each insurance policy paid by the HIPPP program saves an average of \$271.10 annually.

Trauma Settlement Recovery - The objective is to identify potentially liable third parties and to assert liens on litigation settlements to ensure maximum recovery of MO HealthNet expenditures. Each identification is researched to determine if pursuit is cost effective or even possible.

Personal Funds Recovery - The objective of this program is to identify Personal Funds Account Balances of deceased MO HealthNet participants who lived in nursing facilities and recover MO HealthNet expenditures made on behalf of those participants. Nursing facilities are required to pay MO HealthNet within sixty (60) days from the date of death (Section 198.090(7), RSMo).

Burial Plans Recovery - The objective of this program is to recover MO HealthNet expenditures from any excess funds from irrevocable burial plans. Burial lots and irrevocable burial contracts are exempt from consideration in determining MO HealthNet eligibility (Section 208.010, RSMo). The law also provides that if there are excess funds from irrevocable burial plans, the state should recover the excess up to the amount of public assistance benefits provided to the participant.

Estate Recovery - In this program, expenditures are recovered through identification and filing of claims on estates of deceased MO HealthNet participants. Data matches are coordinated with the Department of Health and Senior Services' Vital Statistics, Family Support Division's county offices' staff and cooperation of other public and private groups. When cases are established, staff verify expenditure documentation and assemble data for evidence. The TPL staff appear in court to testify on behalf of the state and explain MO HealthNet policies and procedures.

TEFRA Liens - The Tax Equity and Fiscal Responsibility Act of 1982 authorizes the MO HealthNet program to file a lien as a claim against the real property of certain MO HealthNet participants. The TEFRA lien is for the debt due the state for medical assistance paid or to be paid on behalf of a MO HealthNet participant. TEFRA was implemented with the filing of 13 CSR 70-4.110 which was effective November 30, 2005. Since the implementation, the amount of recoveries attributable to TEFRA is approximately \$7.8 million.

**2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State: RSMo. 198.090, 208.010, 208.153, 208.215, 473.398, 473.399 Federal law: Social Security Act, Section 1902, 1903, 1906, 1912, 1917; Federal regulation: 42 CFR 433 Subpart D

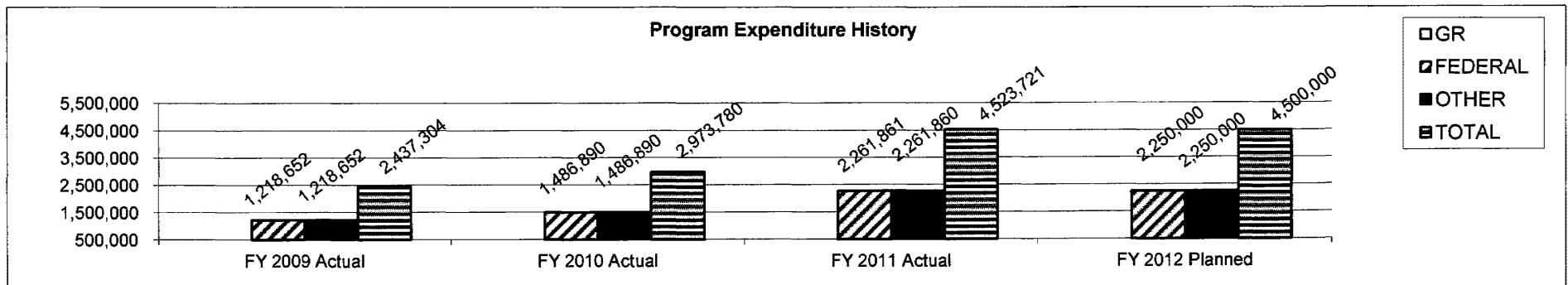
**3. Are there federal matching requirements? If yes, please explain.**

Medicaid administrative expenditures earn a 50% federal match. For every dollar spent, DSS can earn \$0.50 in federal funding.

**4. Is this a federally mandated program? If yes, please explain.**

Yes, if cost effective. In order to not pursue a TPL claim, the agency must obtain a waiver from CMS by proving that a cost recovery effort is not cost effective.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**

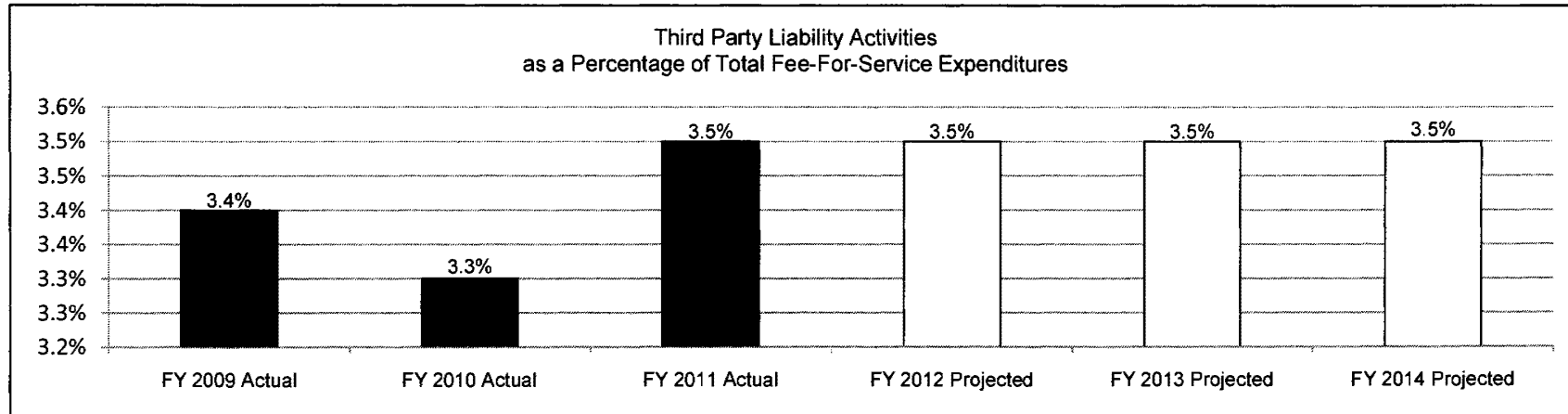


**6. What are the sources of the "Other " funds?**

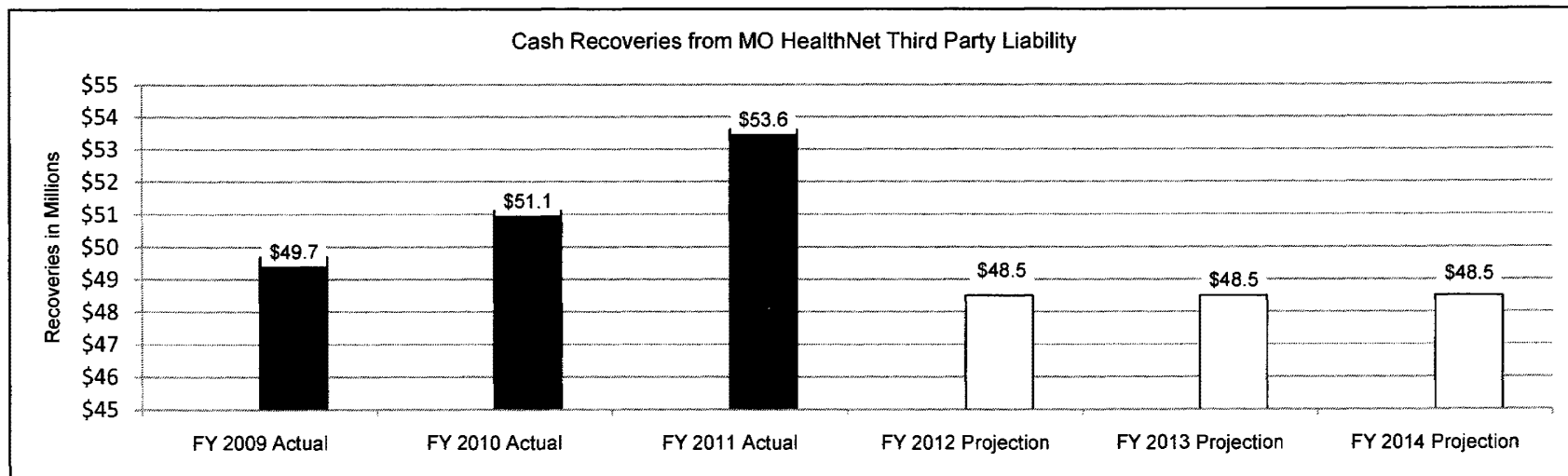
Third Party Liability Collections Fund (0120)

**7a. Provide an effectiveness measure.**

Effectiveness Measure: Third Party Liability (TPL) activities within the MO HealthNet Program ensure that liable third-party resources are being utilized as a primary source of payment in lieu of General Revenue. In state fiscal year 2011, TPL activities, including cost avoidance and cash recovery activities, saved 3.5% of total fee-for-service expenditures.



**7b. Provide an efficiency measure.**



Cash Recoveries by Contractor		
SFY	Actual	Projected
2009	\$26.4 mil	\$16.5 mil
2010	\$28.0 mil	\$21.0 mil
2011	\$32.6 mil	\$24.0 mil
2012		\$26.0 mil
2013		\$26.0 mil
2014		\$26.0 mil

Cash Recoveries by MHD Staff		
SFY	Actual	Projected
2009	\$23.3 mil	\$25.3 mil
2010	\$23.1 mil	\$25.5 mil
2011	\$21.0 mil	\$23.0 mil
2012		\$22.5 mil
2013		\$22.5 mil
2014		\$22.5 mil

MHD is enhancing efforts to obtain timely health insurance carrier information on a proactive basis for MO HealthNet participants to ensure that third party resources are utilized as a primary source of payment in lieu of taxpayer dollars. MHD contracts with a vendor to perform health insurance recoveries and cost avoidance activities. As MHD shifts it's focus to cost avoidance, the trend for health insurance cash recoveries will even out or eventually reflect a decrease.

Actual cash recoveries for all other areas of third party recoveries have shown a decrease over the last few years due to several developments. Medicare providers are performing on-line adjustments rather than submitting reimbursement by check. Cash recoveries for the Estate Program have decreased due to the expanded definition of "estate" not being in statute; a court decision regarding spousal recovery; and the elimination of recovery of Medicare Part B premiums on or after the date of January 1, 2010. Trauma and casualty tort recoveries have decreased as a result of the Ahlborn class action decision.

**7c. Provide the number of clients/individuals served, if applicable.**

**7d. Provide a customer satisfaction measure, if available.**



# **Information Systems**

# FY13 Department of Social Service Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>INFORMATION SYSTEMS</b>								
<b>CORE</b>								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	4,808,643	0.00	4,838,940	0.00	4,838,940	0.00	0	0.00
DEPT OF SOC SERV FEDERAL & OTH	22,238,313	0.00	32,880,170	0.00	32,880,170	0.00	0	0.00
HEALTH CARE TECHNOLOGY FUND	2,110,227	0.00	0	0.00	0	0.00	0	0.00
TOTAL - EE	29,157,183	0.00	37,719,110	0.00	37,719,110	0.00	0	0.00
<b>TOTAL</b>	<b>29,157,183</b>	<b>0.00</b>	<b>37,719,110</b>	<b>0.00</b>	<b>37,719,110</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Sustain MHD Tech Infrastructur - 1886015</b>								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	0	0.00	0	0.00	2,500,000	0.00	0	0.00
DEPT OF SOC SERV FEDERAL & OTH	0	0.00	0	0.00	22,500,000	0.00	0	0.00
TOTAL - EE	0	0.00	0	0.00	25,000,000	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>25,000,000</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$29,157,183</b>	<b>0.00</b>	<b>\$37,719,110</b>	<b>0.00</b>	<b>\$62,719,110</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Information Systems

Budget Unit: 90522C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE	4,838,940	32,880,170		37,719,110
PSD				
TRF				
Total	4,838,940	32,880,170	0	37,719,110
FTE	0.00	0.00	0.00	0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

## 2. CORE DESCRIPTION

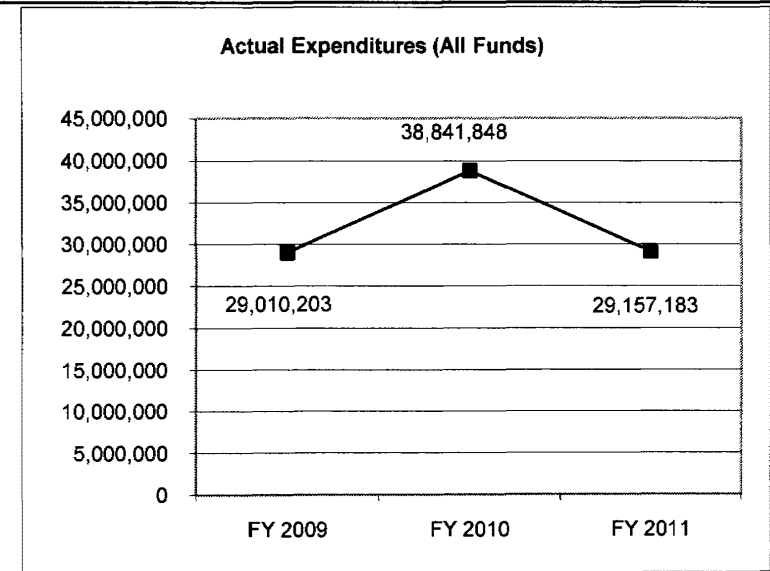
This core request is for the continued funding of MoHealthNet's Information Systems (IS). Core funding is used to pay for the MMIS contract. The MMIS contractor processes fee-for-service claims, managed care encounter data and provides enrollment broker services.

## 3. PROGRAM LISTING (list programs included in this core funding)

Information Systems

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	66,148,456	64,162,098	53,697,622	37,719,110
Less Reverted (All Funds)	(170,923)	(166,965)	(387,545)	N/A
Budget Authority (All Funds)	65,977,533	63,995,133	53,310,077	N/A
Actual Expenditures (All Funds)	29,010,203	38,841,848	29,157,183	N/A
Unexpended (All Funds)	36,967,330	25,153,285	24,152,894	N/A
Unexpended, by Fund:				
General Revenue	0	0	369,328	N/A
Federal	31,670,597	21,036,952	22,057,971	N/A
Other	5,296,733	4,116,333	1,725,595	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

- (1) Lapsed authority is for one-time MMIS reengineering costs spread over several fiscal years. Agency reserve of \$3,269,402 federal funds. The FY2011 core includes a reduction for actual FY2009 one-time MMIS reengineering expenditures.
- (2) Lapsed authority is for one-time MMIS reengineering costs spread over several fiscal years. Agency reserve of \$9,003,565 federal funds and \$1,460,910 in Health Care Technology Funds. The FY2012 core includes a reduction for actual FY2010 one-time MMIS reengineering expenditures of \$11,814,046.
- (3) Lapsed authority is for one-time MMIS reengineering costs spread over several fiscal years. Agency reserve of \$10,633,646 federal funds and \$1,180,400 in Health Care Technology Funds.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES**

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**INFORMATION SYSTEMS**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	EE	0.00	4,838,940	32,880,170	0	37,719,110	
	<b>Total</b>	<b>0.00</b>	<b>4,838,940</b>	<b>32,880,170</b>	<b>0</b>	<b>37,719,110</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	EE	0.00	4,838,940	32,880,170	0	37,719,110	
	<b>Total</b>	<b>0.00</b>	<b>4,838,940</b>	<b>32,880,170</b>	<b>0</b>	<b>37,719,110</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	EE	0.00	4,838,940	32,880,170	0	37,719,110	
	<b>Total</b>	<b>0.00</b>	<b>4,838,940</b>	<b>32,880,170</b>	<b>0</b>	<b>37,719,110</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>INFORMATION SYSTEMS</b>								
<b>CORE</b>								
COMMUNICATION SERV & SUPP	0	0.00	898	0.00	898	0.00	0	0.00
PROFESSIONAL SERVICES	28,655,279	0.00	36,802,112	0.00	36,802,112	0.00	0	0.00
M&R SERVICES	501,904	0.00	916,100	0.00	916,100	0.00	0	0.00
<b>TOTAL - EE</b>	<b>29,157,183</b>	<b>0.00</b>	<b>37,719,110</b>	<b>0.00</b>	<b>37,719,110</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$29,157,183</b>	<b>0.00</b>	<b>\$37,719,110</b>	<b>0.00</b>	<b>\$37,719,110</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$4,808,643	0.00	\$4,838,940	0.00	\$4,838,940	0.00		0.00
FEDERAL FUNDS	\$22,238,313	0.00	\$32,880,170	0.00	\$32,880,170	0.00		0.00
OTHER FUNDS	\$2,110,227	0.00	\$0	0.00	\$0	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Information Systems**

**Program is found in the following core budget(s): Information Systems**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Information Systems processes fee-for-service claims and managed care encounter data through a contractor for the Medicaid Management Information Systems (MMIS). MO HealthNet Managed Care enrollment broker services are included in the MMIS contract.*

The Information Systems (IS) program area includes the MMIS contract and the contract for the enrollment services for the MO HealthNet Managed Care Program. The primary function of Information Systems is to provide the tools and data needed to support administrative and financial decisions and to process fee-for-service claims and MO HealthNet Managed Care encounter data. IS focuses on the gathering, maintenance, analysis, and output of information and data related to claims and a multitude of claims-related interfaces. It is additionally responsible for providing the software and hardware support needed to measure, analyze, assess and manipulate this information in the process of decision making and formulating and testing new systems.

The State contracts with a private entity to operate the subsystems of the Medicaid Management Information System. The subsystems include Claims Processing, Management and Analysis Reporting, Surveillance and Utilization, Reference, Provider, Participant, Third Party Liability and Financial. In order to maintain quality management of MO HealthNet claims, the MO HealthNet Division requires the fiscal agent to:

- ♦ Maintain and enhance a highly automated MO HealthNet claims processing and information retrieval system.
- ♦ Process MO HealthNet claims involving over 41,000 providers of 68 different types, such as hospitals, physicians, dentists, ambulance service providers, nursing homes, therapists, hospices, and managed care health plans.
- ♦ Perform manual tasks associated with processing MO HealthNet claims, and to retrieve and produce utilization and management information that is required by the Division and/or various agencies within the federal government. For example, semi-annual utilization reports are generated for the Program Integrity unit to allow staff to detect and investigate over-utilization patterns and abuse. Third Party Liability (TPL) reports are produced that allow tracking of cost avoidance on claims and provide the capability to perform cost recovery functions.
- ♦ Provide capabilities and/or communications with the Department and the Division via on-line data links to facilitate transfers of data and monitoring of contract issues using menu driven reports and communications via electronic mail.
- ♦ Provide technical support to Managed Care health plans in the maintenance of data lines and the transfer of daily enrollment files and encounter data.

The MMIS is run on a mainframe computer system. There are approximately 35 programmers employed by the fiscal agent to maintain this system. The Interactive Voice Response (IVR) has the availability of approximately 70 incoming lines. The IVR hardware and software allows immediate access to eligibility, payment and claim status information.

The Imaging System allows document storage and retrieval along with a report repository. The fiscal agent supports a web application ([www.emomed.com](http://www.emomed.com)) that supports various provider functions such as claims data entry, send and receive files, electronic remittance advice along with real-time inquiries of claims, attachments, prior authorizations, eligibility and payment status.

The state began contracting with MMIS in 1979. The latest MMIS contract began in FY2008 and was awarded to Infocrossing, Inc. It consists of one year for takeover and transition, six years contracted for operations, and is renewable for three one-year extensions. This new MMIS contract includes seventeen (17) major enhancements scheduled to be implemented over the first few years of the contract period. The highlights of this re-engineering include a new relational database, a rules engine, and browser-based functionality.

**Claims Processing** - Claims processing changes with the two programs, the fee-for-service program versus MO HealthNet Managed Care. Under the fee-for-service program, claims are processed for payment to the provider. Services under MO HealthNet Managed Care which are covered by the capitation payment do not generate a claim. Whomever provides the service is reimbursed by a health plan. The service still results in involvement by IS through the processing of encounter claims. An encounter claim is the same as a regular claim in terms of the information processed such as patient identification, diagnosis and the service(s) provided; it is just not subject to payment. The federal government requires that encounter claims be submitted to the state agency. Encounter claims are transmitted by health plans to the fiscal agent where they are processed and the data is stored.

**Managed Care Impact:** MO HealthNet managed care increases the demand on Information Systems because of the need to interface with numerous different data processing systems. The MMIS system "talks" to the systems run by each of the six individual health plans that contract with the state for Managed Care. Success of the Managed Care program is data-driven. The agency needs encounter data from the health plans in order to set rates and see what services are being provided to agency clients, otherwise on-site audits of thousands of providers would be required. Resolving encounter data and other system problems with individual health plans is staff intensive.

Average claims processing time continues to decrease due to increased electronic claims processing and system improvements from 3.03 days in

**2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State statute: RSMo. 208.166 and 208.201; Federal law: Social Security Act Section 1902(a)(4), 1903(a)(3) and 1915(b); Federal Regulation 42 CFR 433(C) and 438; Children's Health Insurance Program State Plan Amendment.

**3. Are there federal matching requirements? If yes, please explain.**

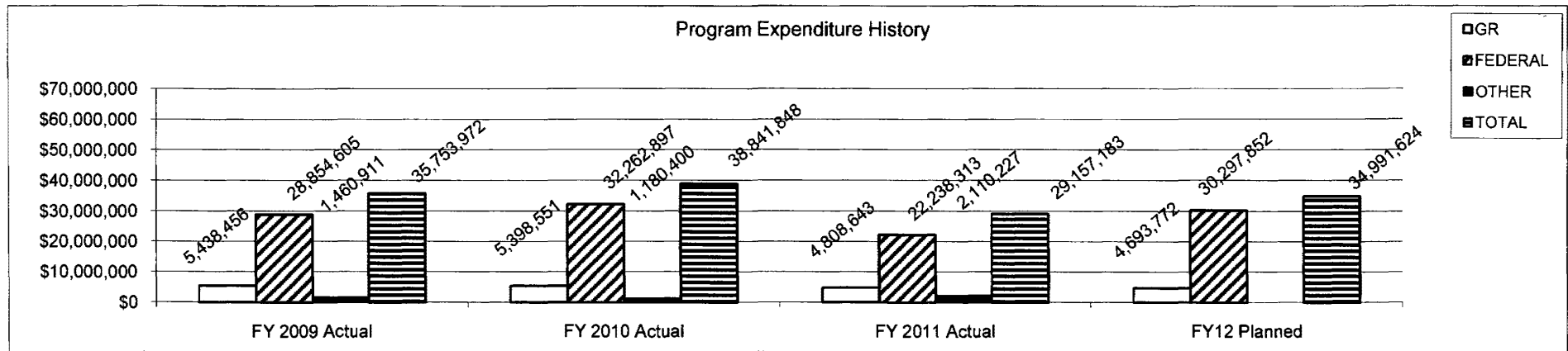
Expenditures for MMIS operations have three different federal financial participation (FFP) rates. The majority of MMIS expenditures earn 75% FFP and require 25% state share. Functions earning 75% include MMIS base operations, call center operations, and enrollment broker services. Approved system enhancements earn 90% FFP and require 10% state share. Postage and Medicaid administrative expenditures earn 50% FFP and requires 50% state share.

**4. Is this a federally mandated program? If yes, please explain.**

Yes. Section 1902(a)(4) of the Social Security Act requires such methods of administration as necessary for the proper and efficient administration of the Medicaid State Plan.



**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



FY2009 expenditures include one-time MMIS reengineering costs. Some costs will carry into subsequent fiscal years.

Reverted: \$145,168 GR

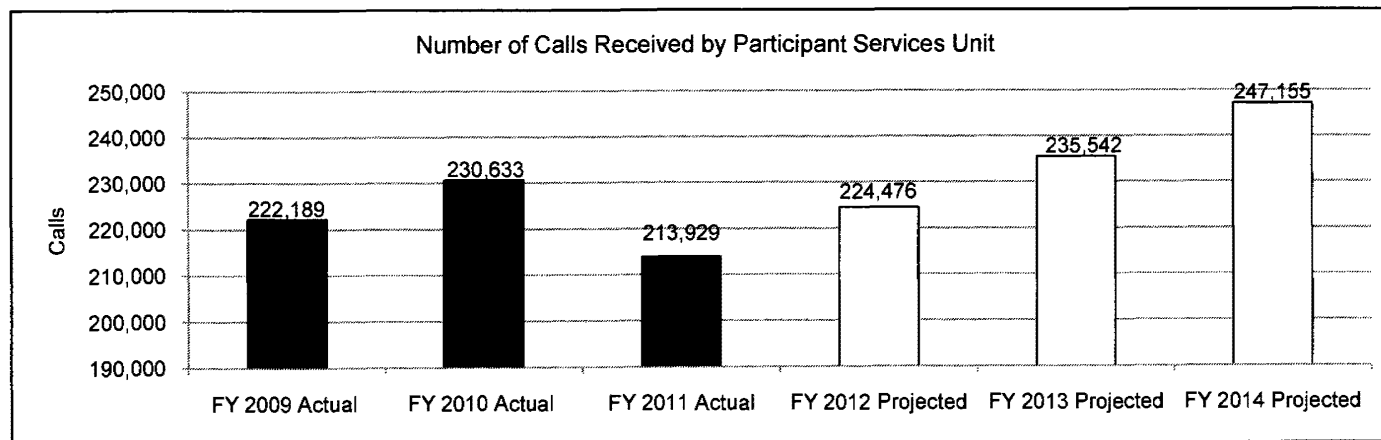
Reserve: \$2,582,318 Federal

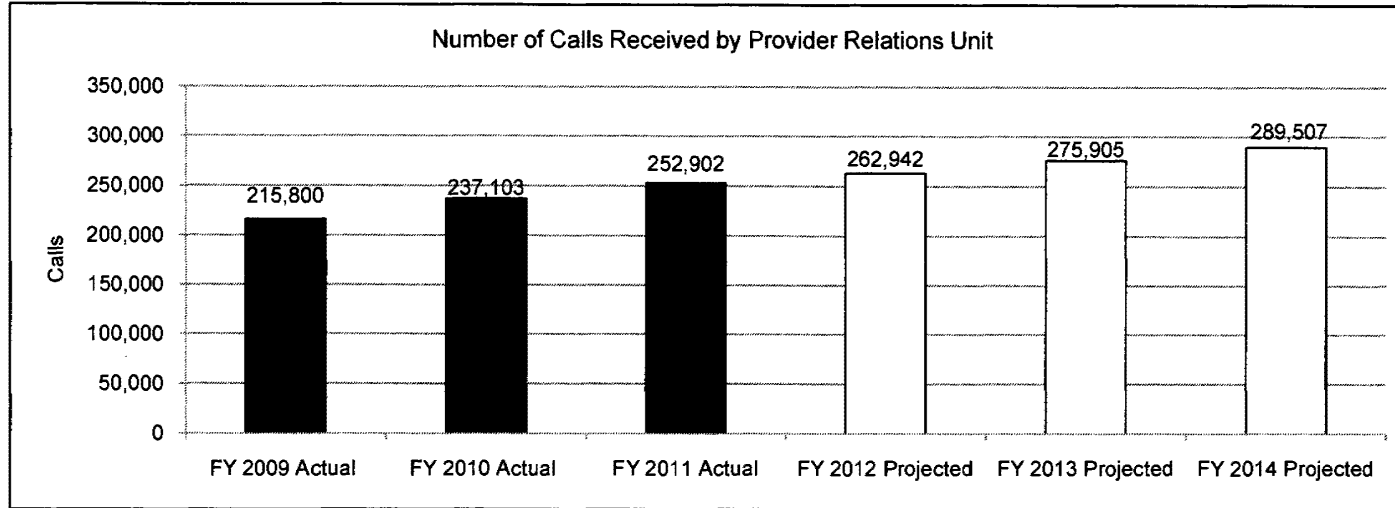
**6. What are the sources of the "Other" funds?**

Healthcare Technology Fund (0170) - FY 2008-2010

**7a. Provide an effectiveness measure.**

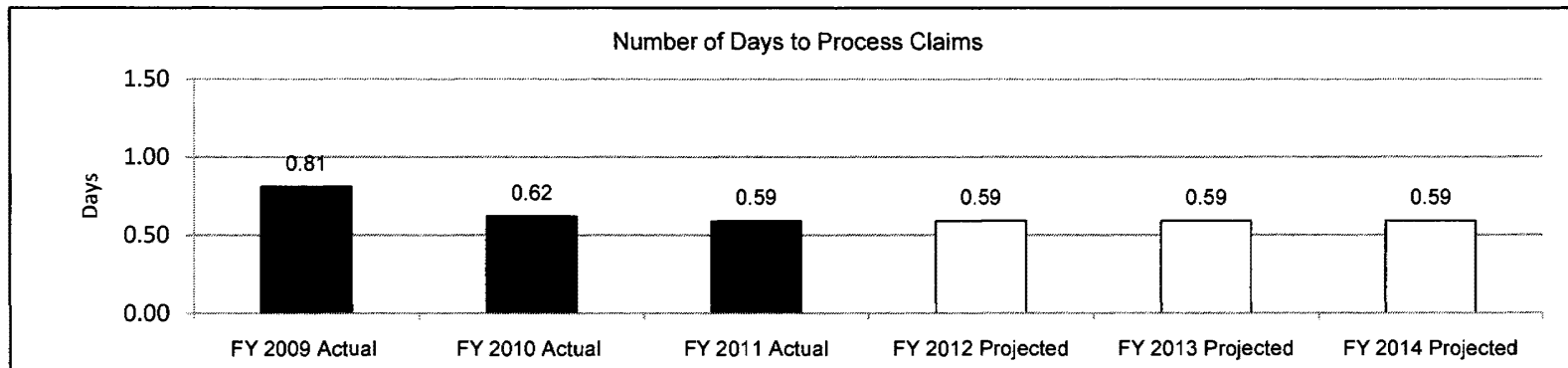
Effectiveness Measure: Provide support for participants and providers. For each of the past three state fiscal years, the Participant Services Unit received and responded to over 215,000 calls from participants. The Provider Relations Unit received and responded to over 250,000 calls in SFY 2011.



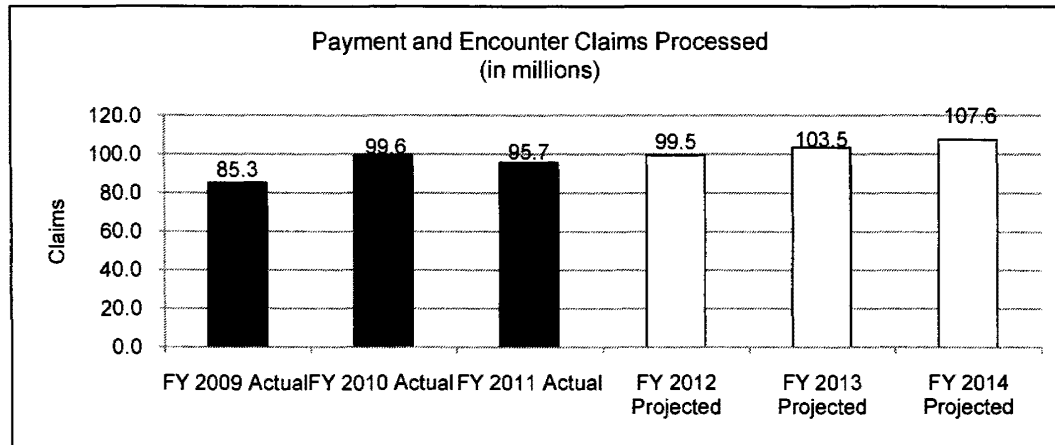


**7b. Provide an efficiency measure.**

Efficiency Measure: Promptly process "clean" claims in less than one day. For the past three fiscal years, claims passing system edits have been processed in less than one day. Processed claims are paid twice a month. In SFY 2011, over 95.7 million claims were processed.



**7c. Provide the number of clients/individuals served, if applicable.**



**7d. Provide a customer satisfaction measure, if available.**

# **Electronic Health Records Incentives**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>ELECTRONIC HLTH RECORDS INCNTV</b>								
<b>CORE</b>								
PROGRAM-SPECIFIC								
FEDERAL STIMULUS-DSS	0	0.00	60,000,000	0.00	60,000,000	0.00	0	0.00
TOTAL - PD	0	0.00	60,000,000	0.00	60,000,000	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>60,000,000</b>	<b>0.00</b>	<b>60,000,000</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Electronic Health Record Incen - 1886019</b>								
PROGRAM-SPECIFIC								
FEDERAL STIMULUS-DSS	0	0.00	0	0.00	38,362,500	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	38,362,500	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>38,362,500</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$0</b>	<b>0.00</b>	<b>\$60,000,000</b>	<b>0.00</b>	<b>\$98,362,500</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Electronic Health Records Incentives

Budget Unit: 90523C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD		60,000,000		60,000,000
TRF				
Total		60,000,000		60,000,000
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

FY 2013 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

## 2. CORE DESCRIPTION

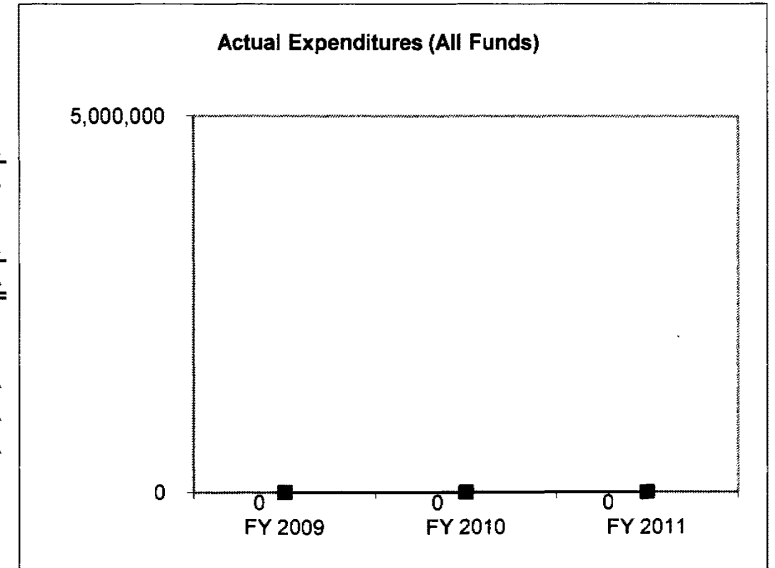
This core request is for the funding of the Missouri's MO HealthNet Electronic Health Record (EHR) Incentive Program. The EHR Incentive Program provides incentive payments for the adoption and meaningful use of certified EHR technology. These incentives are based on the provider's participation in Medicaid programs. The EHR incentive program provides payments to eligible professionals and eligible hospitals for efforts to adopt, implement, upgrade, or meaningfully use certified EHR technology.

## 3. PROGRAM LISTING (list programs included in this core funding)

Electronic Health Records Incentives

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	0	0	0	60,000,000
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	0	0	0	N/A
Actual Expenditures (All Funds)	0	0	0	N/A
Unexpended (All Funds)	0	0	0	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	0	0	0	N/A
Other	0	0	0	N/A



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

Program began in FY 2012.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES**

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**ELECTRONIC HLTH RECORDS INCNTV**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	0	60,000,000	0	60,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>60,000,000</b>	<b>0</b>	<b>60,000,000</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	0	60,000,000	0	60,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>60,000,000</b>	<b>0</b>	<b>60,000,000</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	0	60,000,000	0	60,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>60,000,000</b>	<b>0</b>	<b>60,000,000</b>	



# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
ELECTRONIC HLTH RECORDS INCNTV								
CORE								
PROGRAM DISTRIBUTIONS	0	0.00	60,000,000	0.00	60,000,000	0.00	0	0.00
TOTAL - PD	0	0.00	60,000,000	0.00	60,000,000	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$60,000,000	0.00	\$60,000,000	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$60,000,000	0.00	\$60,000,000	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

## PROGRAM DESCRIPTION

**Department:** Social Services

**Program Name:** Electronic Health Records Incentive

**Program is found in the following core budget(s):** Electronic Health Records Incentive

### 1. What does this program do?

*PROGRAM SYNOPSIS: The Health Information Technology and Clinical Health Act (HITECH) offers incentive payments to encourage eligible professionals and hospitals to adopt certified Electronic Health Records (EHRs).*

Missouri's Medicaid EHR Incentive Program became operational on April 4, 2011. To qualify for Medicaid incentive payments during the first year, participants must meet volume thresholds for Medicaid patients and show that they have adopted, implemented, or upgraded to certified EHR technology. In subsequent years, payments require demonstration of meaningful use of certified EHR technology. Under the program, eligible professionals can receive up to \$63,750 in incentive payments over six years; hospital amounts are based on an established formula.

Eligible professionals (EPs) include physicians, dentists, certified nurse midwives, nurse practitioners; and physician assistants practicing in rural health clinics or Federally-Qualified Health Centers (FQHCs) led by a physician assistant. EPs must have at least a 30% patient volume attributable to Medicaid (20% for pediatricians). EPs can base their volume on either their *individual* Medicaid patient encounters or the *practice's* Medicaid patient encounters. Encounters include both fee-for-service and managed care for which Medicaid paid in whole or in part. Eligible hospitals (EHs) include: acute care hospitals, all stand-alone children's hospitals, cancer hospitals, and critical access hospitals. Except for children's hospitals, EHs must have at least 10% Medicaid patient volume.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

Federal law: ARRA Section 4201; Federal Regulation: 42 CFR Parts 412, 413, 422, and 495

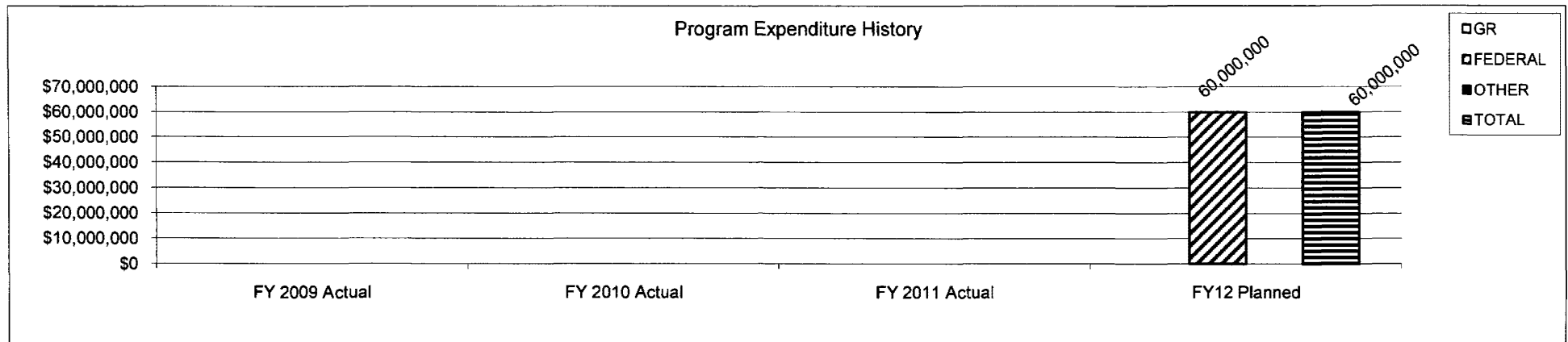
### 3. Are there federal matching requirements? If yes, please explain.

Expenditures for healthcare technology incentives are 100% federal funds.

### 4. Is this a federally mandated program? If yes, please explain.

No.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



**6. What are the sources of the "Other" funds?**

**7a. Provide an effectiveness measure.**

Effectiveness Measure: Increase the number of hospitals and eligible professionals demonstrating meaningful use of EHR technology.

Provider Type	Estimated Number of EHR Participants	
	FY 2012	FY 2013
Hospitals	60	160
Professionals	550	1,650

**7b. Provide an efficiency measure.**

**7c. Provide the number of clients/individuals served, if applicable.**

**7d. Provide a customer satisfaction measure, if available.**

**NEW DECISION ITEM  
RANK: 17**

Department: Social Services  
Division: MO HealthNet  
DI Name: Electronic Health Record Incentives

Budget Unit: 90523C  
DI#: 1886019

**1. AMOUNT OF REQUEST**

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD		38,362,500		38,362,500
TRF				
<b>Total</b>		<b>38,362,500</b>		<b>38,362,500</b>
 FTE				<b>0.00</b>

<b>Est. Fringe</b>	0	0	0	0
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*Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.*

Other Funds:

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
<b>Total</b>				
 FTE				

<b>Est. Fringe</b>	0	0	0	0
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*Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.*

Other Funds:

**2. THIS REQUEST CAN BE CATEGORIZED AS:**

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Increase federal authority	

**3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.**

*PROGRAM SYNOPSIS: The Health Information Technology and Clinical Health Act (HITECH) offers incentive payments to encourage eligible professionals and hospitals to adopt certified Electronic Health Records (EHRs).*

Missouri's Medicaid EHR Incentive Program became operational on April 4, 2011. To qualify for Medicaid incentive payments during the first year, participants must meet volume thresholds for Medicaid patients and show that they have adopted, implemented, or upgraded to certified EHR technology. In subsequent years, payments require demonstration of meaningful use of certified EHR technology. Under the program, eligible professionals can receive up to \$63,750 in incentive payments over six years; hospital amounts are based on an established formula. This funding is for second year payments.

**4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)**

Eligible professionals (EPs) include physicians, dentists, certified nurse midwives, nurse practitioners; and physician assistants practicing in rural health clinics or Federally-Qualified Health Centers (FQHCs) led by a physician assistant. EPs must have at least a 30% patient volume attributable to Medicaid (20% for pediatricians). EPs can base their volume on either their *individual* Medicaid patient encounters or the *practice's* Medicaid patient encounters. Encounters include both fee-for-service and managed care for which Medicaid paid in whole or in part. Eligible hospitals (EHs) include: acute care hospitals, all stand-alone children's hospitals, cancer hospitals, and critical access hospitals. EHs must have at least 10% Medicaid patient volume, except for Children's hospitals.

Projected FY 13 payments include funding for 60 hospitals at \$700,000 each, 40 hospitals at \$1,000,000 each, 550 professionals at \$8,500 each, and 550 professionals at \$21,250 each. Total funding \$98,362,500. This decision item is for the additional funding is excess of the current \$60,000,000 appropriation.

	Total	GR	Federal
Total	\$38,362,500	\$0	\$38,362,500

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	0		38,362,500		0		38,362,500		
Total PSD	0		38,362,500		0		38,362,500		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	38,362,500	0.0	0	0.0	38,362,500	0.0	0

5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.									
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

**6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)**

**6a. Provide an effectiveness measure.**

Effectiveness Measure: Increase the number of hospitals and eligible professionals demonstrating meaningful use of EHR technology.

Provider Type	Estimated Number of EHR Participants	
	FY 2012	FY 2013
Hospitals	60	160
Professionals	550	1650

**6b. Provide an efficiency measure.**

**6c. Provide the number of clients/individuals served, if applicable.**

**6d. Provide a customer satisfaction measure, if available.**

**7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:**

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
ELECTRONIC HLTH RECORDS INCNTV								
Electronic Health Record Incen - 1886019								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	38,362,500	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	38,362,500	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$38,362,500	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$38,362,500	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00



# Pharmacy

# FY13 Department of Social Services Report #9

# DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>PHARMACY</b>								
<b>CORE</b>								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	6,434,520	0.00	207,578	0.00	207,578	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	8,296,436	0.00	207,578	0.00	207,578	0.00	0	0.00
TOTAL - EE	14,730,956	0.00	415,156	0.00	415,156	0.00	0	0.00
PROGRAM-SPECIFIC								
GENERAL REVENUE	95,450,417	0.00	142,023,204	0.00	142,023,204	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	542,428,251	0.00	613,775,746	0.00	613,775,746	0.00	0	0.00
PHARMACY REBATES	104,155,927	0.00	104,155,927	0.00	104,155,927	0.00	0	0.00
THIRD PARTY LIABILITY COLLECT	5,252,468	0.00	5,252,468	0.00	5,252,468	0.00	0	0.00
PHARMACY REIMBURSEMENT ALLOWAN	60,541,801	0.00	64,361,960	0.00	64,361,960	0.00	0	0.00
HEALTH INITIATIVES	940,214	0.00	969,293	0.00	969,293	0.00	0	0.00
HEALTHY FAMILIES TRUST	1,041,034	0.00	1,041,034	0.00	1,041,034	0.00	0	0.00
LIFE SCIENCES RESEARCH TRUST	26,313,901	0.00	35,556,250	0.00	35,556,250	0.00	0	0.00
PREMIUM	3,800,000	0.00	3,800,000	0.00	3,800,000	0.00	0	0.00
TOTAL - PD	839,924,013	0.00	970,935,882	0.00	970,935,882	0.00	0	0.00
<b>TOTAL</b>	<b>854,654,969</b>	<b>0.00</b>	<b>971,351,038</b>	<b>0.00</b>	<b>971,351,038</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Caseload Growth - 1886006</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	4,422,101	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	7,458,880	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	11,880,981	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>11,880,981</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Pharmacy PMPM Increase - 1886014</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	13,548,597	0.00	0	0.00

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN	
<b>PHARMACY</b>									
Pharmacy PMPM Increase - 1886014									
PROGRAM-SPECIFIC									
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	22,852,792	0.00	0	0.00	
TOTAL - PD	0	0.00	0	0.00	36,401,389	0.00	0	0.00	
TOTAL	0	0.00	0	0.00	36,401,389	0.00	0	0.00	
<b>GRAND TOTAL</b>	<b>\$854,654,969</b>	<b>0.00</b>	<b>\$971,351,038</b>	<b>0.00</b>	<b>\$1,019,633,408</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	

# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Pharmacy

Budget Unit: 90541C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE	207,578	207,578		415,156
PSD	142,023,204	613,775,746	215,136,932	970,935,882
TRF				
Total	142,230,782	613,983,324	215,136,932	971,351,038

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				

FTE

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Pharmacy Rebates Fund (0114)  
Third Party Liability Collections Fund (TPL) (0120)  
Pharmacy Reimbursement Allowance Fund (0144)  
Health Initiatives Fund (HIF) (0275)  
Healthy Families Trust Fund (0625)  
Premium Fund (0885)  
Life Sciences Research Trust Fund (0763)

Note: An "E" is requested for the \$104,155,927 Pharmacy Rebates Fund and for the \$64,361,960 Pharmacy Reimbursement Allowance Fund.

## 2. CORE DESCRIPTION

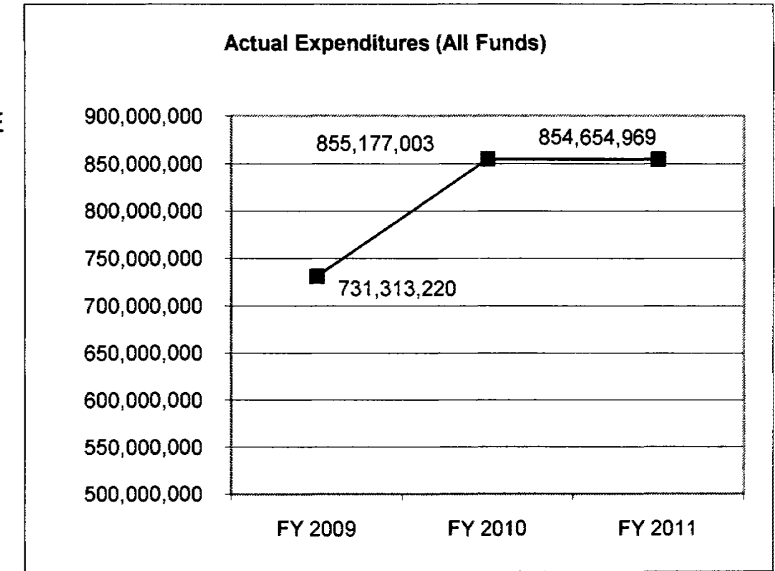
This core request is for the continued funding of the pharmacy program. This funding is necessary to maintain pharmacy reimbursement at a sufficient level to ensure quality health care and provider participation. Funding provides pharmacy services for both managed care and fee-for-service populations. Beginning on October 1, 2009, pharmacy services were carved-out of the managed care capitation rates and the state began administering the pharmacy benefit for participants enrolled in managed care.

## 3. PROGRAM LISTING (list programs included in this core funding)

Pharmacy

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	897,730,792	985,174,582	875,235,929	971,351,038 E
Less Reverted (All Funds)	(67,943,111)	(11,808,179)	(7,821,501)	N/A
Budget Authority (All Funds)	829,787,681	973,366,403	867,414,428	N/A
Actual Expenditures (All Funds)	731,313,220	855,177,003	854,654,969	N/A
Unexpended (All Funds)	98,474,461	118,189,400	12,759,459	N/A
Unexpended, by Fund:				
General Revenue	15,097,538	0	296,528	N/A
Federal	62,421,155	109,387,102	8,208,875	N/A
Other	20,955,764	8,802,297	4,254,056	N/A
	(1)(2)	(3)(4)(5)	(6)(7)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

Estimated "E" appropriation for Pharmacy Rebates Fund and Pharmacy Reimbursement Allowance Fund.

(1) "E" increases of \$30,000,000 Pharmacy Rebates and \$82,600,000 Pharmacy Reimbursement Allowance.

(2) Agency reserve of \$5,100,000 General Revenue and \$4,670,778 Third Party Liability Collections.

(3) "E" increases of \$11,500,000 Pharmacy Rebates and \$45,100,000 Pharmacy Reimbursement Allowance.

(4) Agency reserve of \$39,948,777 Federal and \$8,800,000 Pharmacy Rebates.

Expenditures of \$10,759,974 paid from the Supplemental Pool.

(5) Beginning October 1, 2009 pharmacy services were carved-out of the managed care capitation rates and MO HealthNet began administering the pharmacy benefit through fee for service.

(6) "E" increase of \$4,988,293 Pharmacy Reimbursement Allowance Fund.

(7) Agency reserve of \$7,792,422 Federal and \$9,242,349 Life Sciences Research Trust Fund.

Expenditures of \$27,365,119 from Supplemental Pool.

#### 4. FINANCIAL HISTORY

Cost Per Eligible - Per Member Per Month (PMPM)					
	Pharmacy PMPM*	Acute Care PMPM	Total PMPM	Pharmacy Percentage of Acute	Pharmacy Percentage of Total
PTD	\$289.44	\$953.39	\$1,579.47	30.36%	18.33%
Seniors	\$32.17	\$332.63	\$1,293.02	9.67%	2.49%
Custodial Parents	\$87.67	\$403.27	\$416.87	21.74%	21.03%
Children**	\$42.29	\$232.18	\$251.39	18.21%	16.82%
Pregnant Women	\$49.38	\$507.64	\$515.09	9.73%	9.59%

\* Claims only from FY 11 Table 23 Medical Statistics.  
 \*\* CHIP eligibles not included

The Cost per Eligible - Per Member Per Month (PMPM) table provides the total PMPM for each large eligibility group. Health care entities use per member per month calculations as a benchmark to monitor, assess, and manage health care costs. The PMPM metric provides MHD management with a high level aggregate spending metric.

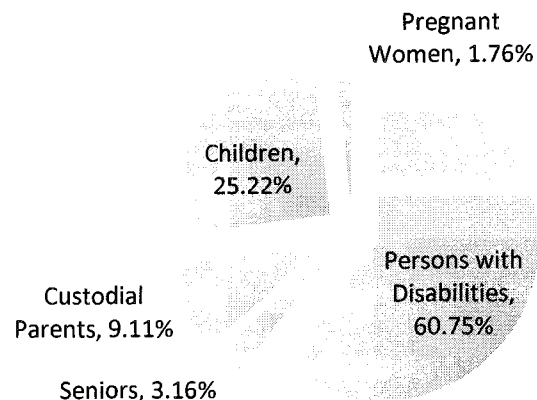
PMPM is calculated by dividing costs by the number of eligibles enrolled. Since caseload growth is accounted for when determining PMPM, the PMPM provides management with a better tool than just comparing overall increases in spending.

PMPM by eligibility group and type of service serves as a baseline for management to determine if cost control interventions are working as intended. Monitoring PMPM amounts allow tracking by a population so that a shift in services is reflected in one metric.

The PMPM table reflects the PMPM amounts for pharmacy, acute care, and total. The acute care PMPM is made up of payments for the following services: inpatient, physician/lab/x-ray, outpatient/clinic, pharmacy, managed care payments, Medicare co-pay/deductibles, dental and other acute services administered by MHD. It does **not** include nursing facilities, in-home services, mental health services and state institutions. By comparing the pharmacy PMPM to the acute care PMPM, MHD management can monitor the progress of interventions controlled by MHD management.

The Spending by Large Eligibility Group (left) shows the percentage of spending by each eligibility group for pharmacy services. It provides a snapshot of what eligibility groups are receiving pharmacy services, as well as the populations impacted by program changes.

#### Pharmacy Spending by Large Eligibility Group



Source: Table 23 Medical Statistics for Fiscal Year 2011

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES**

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**PHARMACY**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	EE	0.00	207,578	207,578	0	415,156	
	PD	0.00	142,023,204	613,775,746	215,136,932	970,935,882	
	<b>Total</b>	<b>0.00</b>	<b>142,230,782</b>	<b>613,983,324</b>	<b>215,136,932</b>	<b>971,351,038</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	EE	0.00	207,578	207,578	0	415,156	
	PD	0.00	142,023,204	613,775,746	215,136,932	970,935,882	
	<b>Total</b>	<b>0.00</b>	<b>142,230,782</b>	<b>613,983,324</b>	<b>215,136,932</b>	<b>971,351,038</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	EE	0.00	207,578	207,578	0	415,156	
	PD	0.00	142,023,204	613,775,746	215,136,932	970,935,882	
	<b>Total</b>	<b>0.00</b>	<b>142,230,782</b>	<b>613,983,324</b>	<b>215,136,932</b>	<b>971,351,038</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>PHARMACY</b>								
<b>CORE</b>								
PROFESSIONAL SERVICES	14,730,956	0.00	415,156	0.00	415,156	0.00	0	0.00
TOTAL - EE	14,730,956	0.00	415,156	0.00	415,156	0.00	0	0.00
PROGRAM DISTRIBUTIONS	839,924,013	0.00	970,935,882	0.00	970,935,882	0.00	0	0.00
TOTAL - PD	839,924,013	0.00	970,935,882	0.00	970,935,882	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$854,654,969</b>	<b>0.00</b>	<b>\$971,351,038</b>	<b>0.00</b>	<b>\$971,351,038</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$101,884,937	0.00	\$142,230,782	0.00	\$142,230,782	0.00		0.00
FEDERAL FUNDS	\$550,724,687	0.00	\$613,983,324	0.00	\$613,983,324	0.00		0.00
OTHER FUNDS	\$202,045,345	0.00	\$215,136,932	0.00	\$215,136,932	0.00		0.00



## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Pharmacy**

**Program is found in the following core budget(s): Pharmacy**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides payment for pharmacy services for fee-for-service and managed care MO HealthNet participants.*

This Pharmacy Services section provides funding for prescription drugs produced by manufacturers for which there exists a rebate agreement between the manufacturer and the federal Department of Health and Human Services (HHS) and dispensed by qualified providers. Since January 1, 1991, the MO HealthNet program has provided reimbursement for all outpatient drugs (except for those which are specifically excluded) for which there is a manufacturer's rebate agreement. While over-the-counter products do not require a prescription for sale to the general public, a prescription for those selected types of over-the-counter products that qualify for MO HealthNet coverage is required in order for the product to be reimbursable. In general terms, MO HealthNet drug reimbursement is made at the lower of: the Wholesale Acquisition Cost (WAC) plus 10%; the Federal Upper Limit (FUL); the Missouri Maximum Acquisition Cost (MAC); or the billed charge. MO HealthNet uses its electronic tools incorporating clinical criteria derived from best practices and evidence-based medical information to adjudicate claims through Clinical Edits, Preferred Drug List Edits, and Prior Authorization.

The U.S. Congress created the Medicaid outpatient prescription drug rebate program when it enacted the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). The goal of the program is to reduce the cost of outpatient prescription drugs by requiring drug manufacturers to pay a rebate directly to state Medicaid programs. The purpose of the program is to reduce the cost of prescription drugs without placing an undue burden on pharmacies by requiring the drug manufacturers to pay a rebate directly to the state Medicaid programs. The intent of this rebate is to allow the state and federal governments to receive price reductions similar to those received by other high volume purchasers of drugs.

#### Rebate Program

OBRA '90 requires all drug manufacturers to enter into a drug rebate agreement with the Department of Health and Human Services before their product lines will be eligible for coverage by Medicaid. Currently, 500 manufacturers have signed agreements with Centers for Medicare and Medicaid Services (CMS) and participate in the Drug Rebate Program. Approximately 400 manufacturers have products dispensed and are invoiced quarterly. Once the drug manufacturer has entered into the agreement, the state Medicaid programs are required to provide coverage of the manufacturers' drug products. However, the state has the option of excluding certain categories of the manufacturer's products or requiring prior authorization for reimbursement of products. Manufacturers are required to calculate and make rebate payments to the state Medicaid agency for the manufacturer's covered outpatient drugs reimbursed by the state during each quarter. Manufacturers are to be invoiced no later than sixty days after the end of each calendar quarter and are required to make payment for the calculated drug rebate directly to the state Medicaid program within 38 days of invoicing. For generic drugs, the rebate amount is currently 11% of Average Manufacturer Price (AMP). For single-source drugs, the rebate is the greater of 15% of AMP or the difference between the AMP and the manufacturer's "best price", plus CPI-U factors. The Affordable Care Act of 2010 increased the minimum rebate from 15% to 23% for single-source drugs. Section 2501 of the Affordable Care Act also required that 100% of these increased rebates are remitted to the federal government, instead of being shared at the normal federal matching rate. The manufacturer has the option of disputing the calculated drug rebate amount if the manufacturer disagrees with the state's drug utilization data. The manufacturer is required to report the nature of the dispute to the state, and the state is then responsible for resolving the dispute through negotiation or a hearing process, if necessary. Approximately 37% of the total rebates collected are used as a state share funding source rather than using General Revenue funds. The approximate 63% federal share of the rebates collected is returned to the federal government.

#### Prior Authorization

Any covered outpatient drug can be subject to prior authorization. Effective August 1, 1992, a prior authorization (PA) process was implemented for certain specific drugs under the pharmacy program.

Drug PA requests are received via telephone, fax or mail. All requests for drug PA must be initiated by a physician or authorized prescriber (advanced practice nurse) with prescribing authority for the drug category for which a PA is being requested. As specified in OBRA 90, drug PA programs must provide a response by telephone or other telecommunication device within 24 hours of receipt. All requests must include all required information. Requests received with insufficient information for review or received from someone other than a physician or authorized prescriber will not initiate a PA review nor the 24-hour response period. Drug PA requests received via telephone are keyed on-line and notification of approval will be given at the time of the call or by return FAX or phone call. The MO HealthNet Technicians who staff this hotline work through algorithms developed by the Drug Prior Authorization Committee with the assistance of UMKC-DIC, School of Pharmacy. These algorithms are sets of questions used to make a determination to approve or deny the request. Making the prior authorization determination on-line allows the PA file to be updated immediately. For approvals, the requestor will be given an authorization period. Pharmacies may record this information for this purpose as well.

#### Board and Committee Support and Oversight

The MO HealthNet Oversight Committee was created in 2007 and is charged with evaluating the program and its implementation.

The MO HealthNet Division operates both prospective and retrospective Drug Utilization Review (DUR) as required by federal and state law. The DUR program is focused on educating health care providers in the appropriate use of medications, and informing them of potential drug therapy problems found in the review of drug and diagnostic information obtained from MO HealthNet claims history. The DUR Board is central to all DUR program activities, and its duties and membership requirements are specified in state and federal law. DUR Board members are appointed by the Governor with advice and consent of the Senate, and its 13 members include six physicians, six pharmacists, and one quality assurance nurse. In an ongoing process, the DUR Board reviews and makes changes to the clinical therapeutic criteria used to generate prospective and retrospective DUR interventions. The DUR Board also advises the Division on other issues related to appropriate drug therapy and produces a quarterly newsletter for providers on selected drug topics. In addition to the Board, a Regional DUR Committee, comprised of physicians and pharmacists, evaluates individual participants' retrospective drug regimens and advises their providers on appropriate drug use or potentially problematic drug therapies.

The MO HealthNet Drug Prior Authorization (PA) Committee is established in state regulation. This advisory committee is charged with reviewing drugs and recommending those drugs which are appropriate for reimbursement as a regular benefit verses those which should be placed on prior authorization status. All such recommendations made by the Drug PA Committee are referred to the DUR Board, as they are the statutorily-appointed advisory group for final recommendation to the Division.

#### Cost Containment Initiatives

As a result of new drugs, rapidly changing prescribing patterns and increased expenditures in the MO HealthNet fee-for-service pharmacy program, the MO HealthNet program continues to implement a number of administrative measures to ensure the economic and efficient provision of the MO HealthNet pharmacy benefit. These strategies have been developed through recommendations from a number of sources, including affected state agencies, provider groups, and the pharmaceutical industry. The intent of these initiatives is to ensure that MO HealthNet participants get the right drug to meet their needs, in the right amount and for the right period of time. Examples of some of the cost containment initiatives include:

**Expanded Missouri Maximum Allowable Cost (MAC) List:** The list of drugs for which the state agency has established a generic reimbursement limit will be monitored and expanded on a regular basis. A mechanism is in place to review existing MACs as well as identifying new generic drugs for addition to this list, as they become available. This optimizes generic utilization in the MO HealthNet program.

The Preferred Drug List (PDL) utilizes information from various clinical sources, including the UMKC Drug Information Center, the Oregon Evidence-Based Drug Research Consortium, our clinical contractors, and our own clinical research team. Clinical information is paired with fiscal evaluation to develop a therapeutic class recommendation. The resulting PDL process incorporates clinical edits, including step therapies, into the prescription drug program. Clinical edits are designed to enhance patient care and optimize the use of program funds through therapeutically prudent use of pharmaceuticals. Point-of-sale (POS) pharmacy claims are routed through an automated computer system to apply edits specifically designed to ensure effective and appropriate drug utilization. The goal is to encourage cost effective therapy within the selected drug class.

Specialty medications include high-cost injectable, infused, oral, or inhaled drugs that involve specific handling, supervision or monitoring. MO HealthNet will continue to review specialty medications within each of the therapeutic categories to identify clinical editing, preferred drug list (PDL) and prior authorization (PA) opportunities. MO HealthNet is focusing on opportunities to reduce expenditures without compromising participant outcomes. One example is the Missouri Maximum Allowable Cost (MAC) Pricing for Specialty Drugs. The MAC specialty program follows MO HealthNet pricing methodology, utilizing Wholesale Acquisition Cost (WAC), pricing generally available to providers, as a basis for pricing the identified specialty medications. In accordance with MO HealthNet MAC program policy, MO HealthNet staff monitors and updates the more inclusive Missouri MAC list.

**Edits - Dose Optimization:** Effective for dates of service on or after April 16, 2002, claims submitted to the MO HealthNet Pharmacy Program are subject to edits to identify claims for pharmacy services that fall outside expected patterns of use for certain products. Overrides to these edit denials can be processed through the help desk. Justification for utilization outside expected patterns such as FDA approved labeling is required for approval of such an override.

**Pharmacy Provider Tax:** The Missouri General Assembly passed legislation establishing a tax on licensed retail pharmacies in Missouri for the privilege of providing outpatient prescription drugs. The Department of Social Services has notified each pharmacy of the amount of tax due. The tax began in 2002. Effective July 1, 2007, Missouri pharmacies were given an enhanced dispensing fee of \$4.82, for a total dispensing fee of \$9.66.

Effective for dates of service January 1, 2010 and beyond, the MO HealthNet Pharmacy Program began paying pharmacy providers a generic product preferred incentive fee. This program initiative will continue to emphasize the preference for generic utilization within the MO HealthNet pharmacy program by paying pharmacy providers an enhanced incentive fee of \$4.00 for each eligible claim.

**Prior Authorization of All New Drugs:** Prior authorization is required for all new drug entities and new drug product dosage forms of these products through existing drug entities that have been approved by the Food and Drug Administration and are available on the market. After identifying First Data Bank's weekly updates, the medications are reviewed for medical and clinical criteria along with pharmacoeconomic impact to the pharmacy program.

In December 2003, the MHD moved diabetic testing supplies and syringes from the DME program to the pharmacy program, and initiated a single source diabetic testing supply initiative, continuing to encourage patient blood glucose testing while minimizing state expenditures. In April 2005, the pharmacy program moved to a multi-source diabetic testing supplies initiative. Diabetic testing supply products and syringes are now available in preferred status from multiple manufacturers, providing greater participant choice.

**Enhanced Retrospective Drug Utilization:** Enhanced Retrospective Drug Utilization involves retroactively reviewing population based patterns of drug use to compare those patterns to approved therapeutic guidelines in order to determine the appropriateness of care, length of treatment, drug interaction, and other clinical issues.

**Provider Audits:** Daily provider audits are performed by MHD/WiPro staff for the identification and resolution of potential recoupments.

### Clinical Management Services Program (CMSP)

Through a contract with ACS Heritage, MHD operates an innovative electronic web-based clinical editing process for its point-of-sale pharmacy and medical claims, medical and drug prior authorization, and Drug Utilization Review (DUR) processes. The current CMSP claim processing system allows each claim to be referenced against the participant's claims history including pharmacy, medical and procedural data (ICD-9 and CPT codes), providing real time data to participating MO HealthNet providers. For patients that meet approval criteria, the claim will be paid automatically. In instances when a phone call is necessary, the hotline call center is available seven days a week, which allows providers prompt access to a paid claim for the requested product or service. In addition to receiving messages regarding the outcome of the processing of claims and the amount to be reimbursed, pharmacy providers receive prospective drug use review alert messages at the time prescriptions are dispensed.

The contract with ACS-Heritage utilizes their *CyberAccess*<sup>SM</sup> tool to create integrated patient profiles containing prescription information, as well as patient diagnoses and procedure codes for a running 24 months of history. *CyberAccess*<sup>SM</sup> provides: participant claims history profiles, updated daily, identifying all drugs, procedures, related diagnoses and ordering providers from claims paid by MHD for a rolling 36 month period; and three years of point of sale (POS) pharmacy claims refreshed every ten (10) minutes.

Point-of-service pharmacy - Claims are routed through Heritage's automated system to apply edits specifically designed to assure effective utilization of pharmaceuticals. The edits are founded on evidence-based clinical and nationally recognized expert consensus criteria. Claims will continue to be processed by WiPro for all other edits and final adjudication. After processing by Heritage and WiPro, the claim is sent back to the provider with a total processing time of approximately 10 seconds. Claims which are denied by the system edits will require an override from the existing help desk. Providers seeking an override must contact the help desk for approval, which will be granted if medically necessary.

Fiscal and Clinical Edits - This initiative optimizes the use of program funds and enhances patient care through improved use of pharmaceuticals. Since the implementation of the Omnibus Budget Reduction Act of 1990 (OBRA 90), education on the use of pharmaceuticals has been accomplished primarily through DUR. However, the prospective DUR alerts currently generated by the fiscal agent have been largely ignored by pharmacy providers as they are more general in nature and few are tied to claim reimbursement. Other third party payers have successfully utilized more extensive evidence based claims screening edits in an effort to control costs. Such edits are applicable within the Medicaid program to achieve similar cost controls.

Drug Utilization Review: This process is currently provided by Heritage, and will be an extension of the current process with some enhancements. Under the new contract, this initiative will utilize the same database/computer system as the previously described components. This system uses a relational database capable of interfacing MO HealthNet paid claims history with flexible, high quality clinical evaluation criteria. The process is designed to identify high-risk drug use patterns among physicians, pharmacists, and beneficiaries, and to educate providers (prescribers and dispensers) in appropriate and cost-effective drug use. This process is capable of identifying providers prescribing and dispensing practices which deviate from defined standards, as well as generate provider profiles and ad hoc reports for specified provider and participant populations. The goal of the program is to maximize drug therapy and outcomes, and optimize expenditures for health care.

<b>2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)</b>
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Statute: RSMo. 208.152, 208.166, Federal law: Social Security Act Section 1902(a)(12), Federal regulation: 42 CFR 440.120

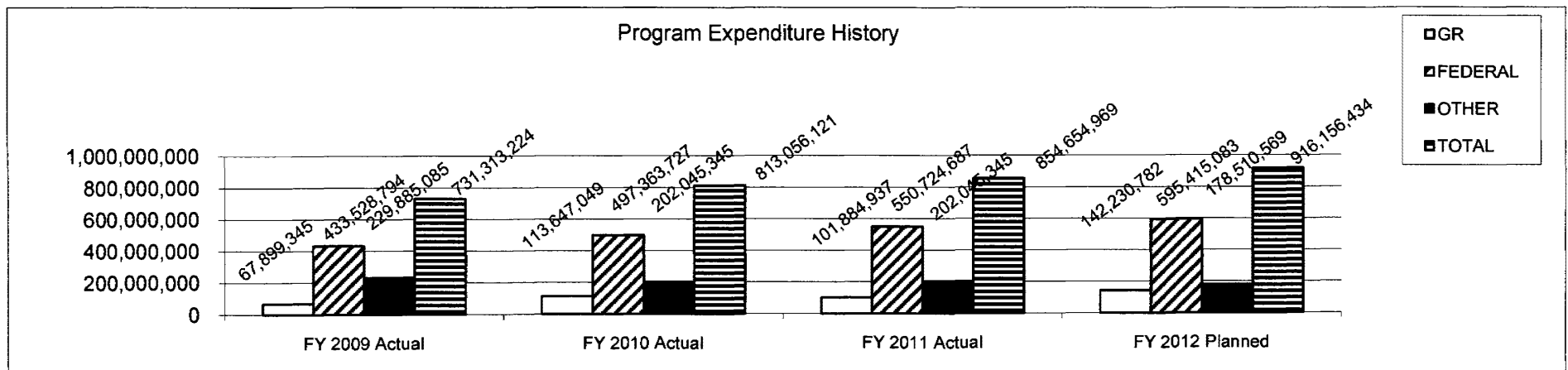
**3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 is a blended 63.41% federal match. The state matching requirement is 36.59%.

**4. Is this a federally mandated program? If yes, please explain.**

Yes for children. No for adults.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



FY12 Reverted: \$29,079 Other Funds

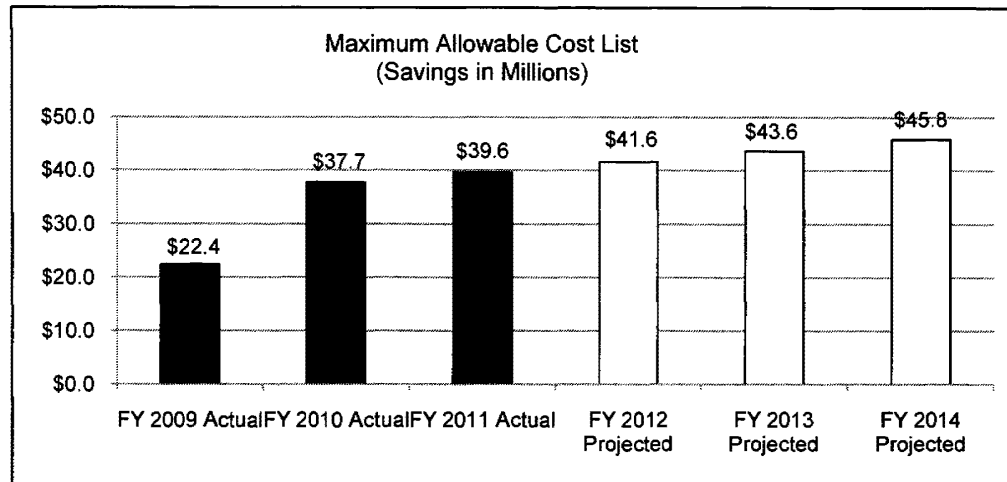
FY12 Reserve: \$18,568,241 Federal Funds and \$1,041,034 Other Funds

FY12 Reserve: \$35,556,250 Life Sciences Research Trust Fund

**6. What are the sources of the "Other " funds?**

Pharmacy Reimbursement Allowance Fund (0144), Pharmacy Rebates Fund (0114), Health Initiatives Fund (0275), Third Party Liability Fund (0120), Healthy Families Trust Fund (0625), Premium (0885) and Life Sciences Research Trust Fund (0763).

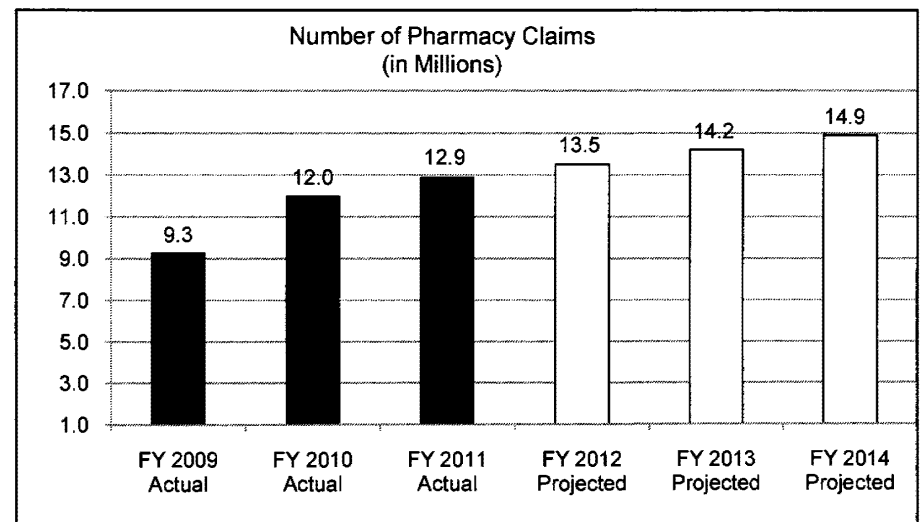
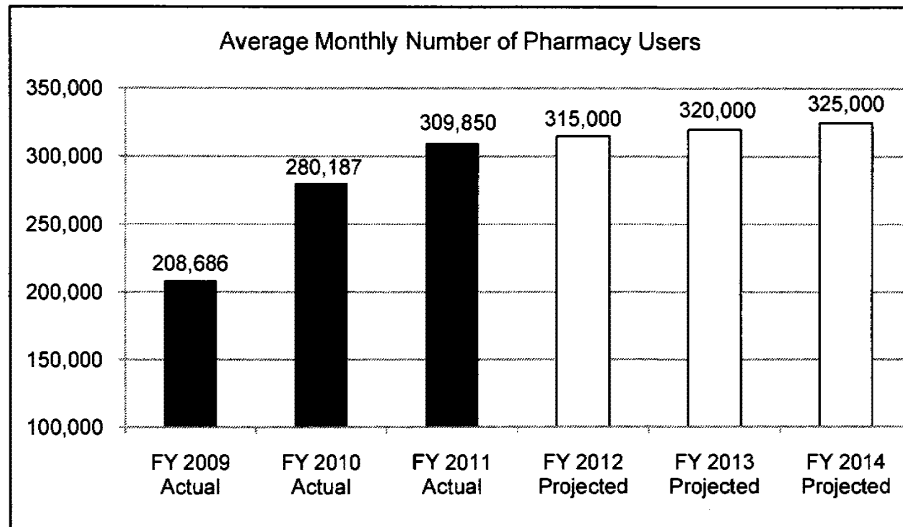
**7a. Provide an effectiveness measure.**



**7b. Provide an efficiency measure.**

**7c. Provide the number of clients/individuals served, if applicable.**

Pharmacy services are available to all MO HealthNet participants. Prior to FY 2010, managed care plans had the option to carve out pharmacy services. Beginning in SFY 2010, managed care plans are no longer responsible for paying for pharmacy services. Pharmacy services for both fee-for-service and managed care are paid from the pharmacy section.



Note: Source of Actual data has changed to provide more accurate information.

**7d. Provide a customer satisfaction measure, if available.**

# **Pharmacy—Medicare Part D Clawback**



# FY13 Department of Social Services #9

# DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PHARMACY-MED PART D-CLAWBACK								
CORE								
PROGRAM-SPECIFIC								
GENERAL REVENUE	139,018,493	0.00	180,575,272	0.00	180,575,272	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	1	0.00	1	0.00	0	0.00
TOTAL - PD	139,018,493	0.00	180,575,273	0.00	180,575,273	0.00	0	0.00
TOTAL	139,018,493	0.00	180,575,273	0.00	180,575,273	0.00	0	0.00
Clawback Increase - 1886009								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	20,507,743	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	20,507,743	0.00	0	0.00
TOTAL	0	0.00	0	0.00	20,507,743	0.00	0	0.00
GRAND TOTAL	\$139,018,493	0.00	\$180,575,273	0.00	\$201,083,016	0.00	\$0	0.00

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Pharmacy-Medicare Part D Clawback

Budget Unit: 90543C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	180,575,272	1		180,575,273 E
TRF				
Total	180,575,272	1		180,575,273 E
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Note: An "E" is requested for the \$1 Federal Funds.

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

## 2. CORE DESCRIPTION

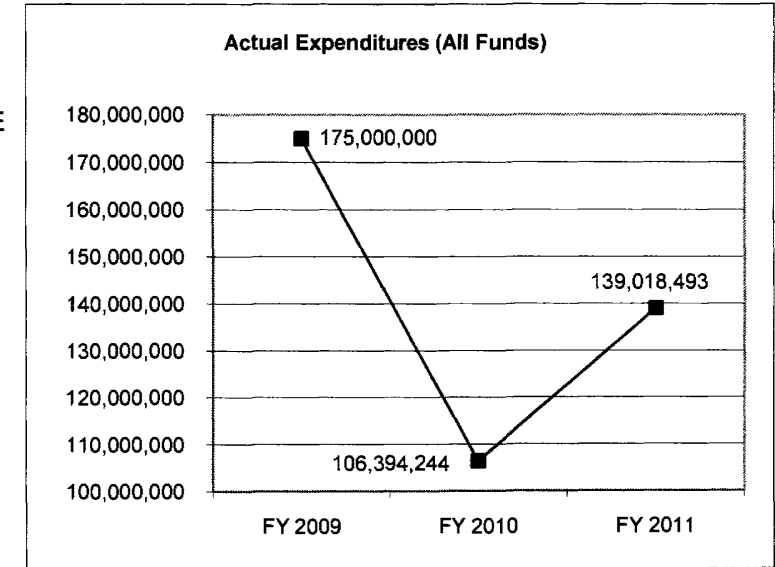
This core request is for the continued funding of the Medicare Part D Clawback. Part of the Medicare Prescription Drug Act requires States to pay Medicare a portion of the cost of Part D drugs attributable to what would have been paid for by the State absent the Part D drug benefit.

## 3. PROGRAM LISTING (list programs included in this core funding)

Pharmacy--Medicare Part D--Clawback

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.	
Appropriation (All Funds)	175,000,001	185,000,001	146,465,011	180,575,273	E
Less Reverted (All Funds)	0	(78,605,756)	0	N/A	
Budget Authority (All Funds)	175,000,001	106,394,245	146,465,011	N/A	
Actual Expenditures (All Funds)	175,000,000	106,394,244	139,018,493	N/A	
Unexpended (All Funds)	1	1	7,446,518	N/A	
Unexpended, by Fund:					
General Revenue	0	0	946,517	N/A	
Federal	1	1	1	N/A	
Other	0	0	6,500,000	N/A	
	(1)	(2)	(3) (4)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

Estimated E for Federal fund appropriation.

(1) Expenditures of \$2,533,496 paid from pharmacy.

(2) ARRA FMAP adjustment resulted in credit (reduced expenditures) of \$78,509,219.

(3) Agency Reserve Missouri RX Plan Fund of \$6,500,000.

(4) ARRA FMAP adjustment (reduced rates) continued into FY 2011.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES**

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**PHARMACY-MED PART D-CLAWBACK**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	180,575,272	1	0	180,575,273	
	<b>Total</b>	<b>0.00</b>	<b>180,575,272</b>	<b>1</b>	<b>0</b>	<b>180,575,273</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	180,575,272	1	0	180,575,273	
	<b>Total</b>	<b>0.00</b>	<b>180,575,272</b>	<b>1</b>	<b>0</b>	<b>180,575,273</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	180,575,272	1	0	180,575,273	
	<b>Total</b>	<b>0.00</b>	<b>180,575,272</b>	<b>1</b>	<b>0</b>	<b>180,575,273</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PHARMACY-MED PART D-CLAWBACK								
CORE								
PROGRAM DISTRIBUTIONS	139,018,493	0.00	180,575,273	0.00	180,575,273	0.00	0	0.00
TOTAL - PD	139,018,493	0.00	180,575,273	0.00	180,575,273	0.00	0	0.00
GRAND TOTAL	\$139,018,493	0.00	\$180,575,273	0.00	\$180,575,273	0.00	\$0	0.00
GENERAL REVENUE	\$139,018,493	0.00	\$180,575,272	0.00	\$180,575,272	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$1	0.00	\$1	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Pharmacy--Medicare Part D Clawback**

**Program is found in the following core budget(s): Pharmacy--Medicare Part D Clawback**

### 1. What does this program do?

*PROGRAM SYNOPSIS: The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 required that all individuals who are eligible for both Medicare and MO HealthNet receive their prescription drugs through the Medicare Part D program. This change resulted in a significant shift in benefits for elderly and disabled dual eligible participants because they receive their drugs through a prescription drug plan (PDP) rather than through the state's MO HealthNet program.*

The federal government refers to this payment as the "Phased-down State Contribution", whereas the states more appropriately refer to the payment as the "clawback". This clawback payment is, in effect, a funding source for the Medicare Part D program. In theory, it uses the General Revenue that the state would have paid for the MO HealthNet pharmacy benefit for funding the Part D program.

States are required to make a monthly payment to the federal government to, in effect, re-direct the money that the states would have spent on providing prescription drugs to participants in the MO HealthNet program. The clawback consists of a monthly calculation based on the combination of (a) the state's per capita spending on prescription drugs in 2003, (b) the state's federal Medicaid match rate, (c) the number of dual eligible's residing in the state, and (d) a "phase-down percentage" of state savings to be returned to the federal government beginning with 90 percent in 2006 and phasing down to 75 percent in 2015. The phased-down percentage for CY 2012 is 80.00%.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, P.L. 108-173.

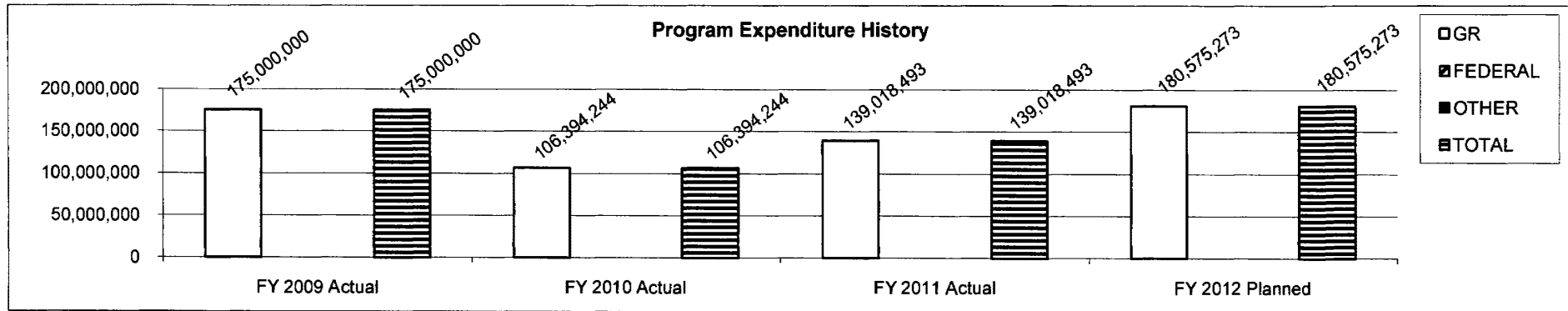
### 3. Are there federal matching requirements? If yes, please explain.

No.

### 4. Is this a federally mandated program? If yes, please explain.

Yes. The states are required to make a monthly payment to the federal government to re-direct the money that the states would have spent on providing prescription drugs to participants in MO HealthNet.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



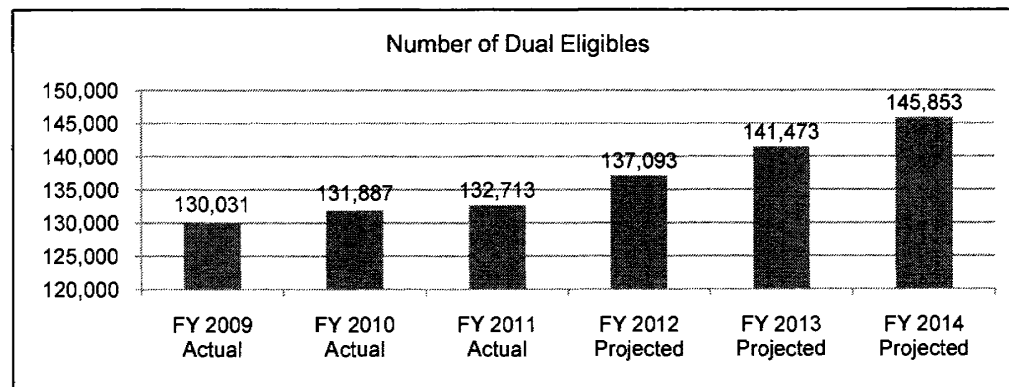
6. What are the sources of the "Other " funds?

N/A

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.



7d. Provide a customer satisfaction measure, if available.

**NEW DECISION ITEM  
RANK: 13**

Department: Social Services  
Division: MO HealthNet  
DI Name: Clawback Increase

Budget Unit: 90543C

DI#: 1886009

**1. AMOUNT OF REQUEST**

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	20,507,743			20,507,743
TRF				
Total	<u>20,507,743</u>			<u>20,507,743</u>
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

**2. THIS REQUEST CAN BE CATEGORIZED AS:**

<input checked="" type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input checked="" type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

**3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.**

*NDI SYNOPSIS: To provide for the anticipated increase in the Clawback payment.*

This decision item requests funding for the increase in General Revenue needed for the payment of the Clawback, as calculated by the Centers for Medicare and Medicaid Services (CMS).



**4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)**

Calculation for the MO HealthNet Clawback payment is shown below. The number of dual (Medicare and Medicaid) eligibles was calculated using the caseload growth for the disabled population and assumed that 44% are Medicare eligible  $((4,939 \text{ eligibles}/12 \text{ months}) * 44\%) = 181$ ). There is no projected growth for the elderly so no increase is being requested for that eligibility group. The clawback assessment was calculated using CMS' methodology. The June assessment is included in the calculation because the assessment is one month in arrears.

Payment Date	Number of Duals	Clawback Rate	Payment
June 2012	136,005	\$119.23	16,215,876.15
July 2012	136,186	\$119.23	16,237,456.78
August 2012	136,367	\$119.23	16,259,037.41
September 2012	136,548	\$119.23	16,280,618.04
October 2012	136,729	\$122.17	16,704,181.93
November 2012	136,910	\$122.17	16,726,294.70
December 2012	137,091	\$122.17	16,748,407.47
January 2013	137,272	\$124.84	17,137,036.48
February 2013	137,453	\$124.84	17,159,632.52
March 2013	137,634	\$124.84	17,182,228.56
April 2013	137,815	\$124.84	17,204,824.60
May 2013	137,996	\$124.84	17,227,420.64
FY 13 Projected Spending			201,083,015.28
FY 12 Available			180,575,272.00
FY 13 Need			\$20,507,743.28

	Total	GR	Federal
Total Request	\$20,507,743	\$20,507,743	\$0

**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	20,507,743						20,507,743		
Total PSD	20,507,743		0		0		20,507,743		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	20,507,743	0.0	0	0.0	0	0.0	20,507,743	0.0	0

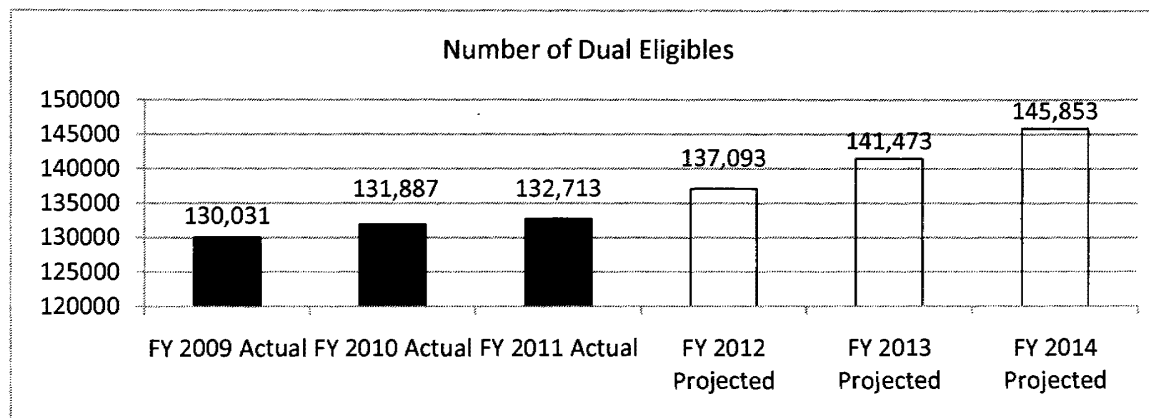
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

**6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)**

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.



6d. Provide a customer satisfaction measure, if available.

**7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:**

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PHARMACY-MED PART D-CLAWBACK								
Clawback Increase - 1886009								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	20,507,743	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	20,507,743	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$20,507,743	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$20,507,743	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# **Missouri Rx Plan**

# FY13 Department of Social Services Report #9

# DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>MISSOURI RX PLAN</b>								
<b>CORE</b>								
EXPENSE & EQUIPMENT								
HEALTHY FAMILIES TRUST	0	0.00	26,600	0.00	26,600	0.00	0	0.00
TOTAL - EE	0	0.00	26,600	0.00	26,600	0.00	0	0.00
PROGRAM-SPECIFIC								
HEALTHY FAMILIES TRUST	13,820,394	0.00	13,793,794	0.00	13,793,794	0.00	0	0.00
MISSOURI RX PLAN FUND	4,802,581	0.00	5,781,772	0.00	5,781,772	0.00	0	0.00
TOTAL - PD	18,622,975	0.00	19,575,566	0.00	19,575,566	0.00	0	0.00
<b>TOTAL</b>	<b>18,622,975</b>	<b>0.00</b>	<b>19,602,166</b>	<b>0.00</b>	<b>19,602,166</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$18,622,975</b>	<b>0.00</b>	<b>\$19,602,166</b>	<b>0.00</b>	<b>\$19,602,166</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Missouri Rx Plan

Budget Unit: 90538C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request			
GR	Federal	Other	Total
PS			
EE		26,600	26,600
PSD		19,575,566	19,575,566
TRF			
Total		19,602,166	19,602,166
FTE		0.00	

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

FY 2013 Governor's Recommendation			
GR	Federal	Other	Total
PS			
EE			
PSD			
TRF			
Total			
FTE			

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds: Missouri Rx Plan Fund (0779)  
Healthy Families Trust Fund (0625)

Note: An "E" is requested for the \$5,781,772 Missouri Rx Plan Fund

## 2. CORE DESCRIPTION

The Missouri Rx Plan provides certain pharmaceutical benefits to certain low-income elderly and disabled residents of the state, facilitates coordination of benefits between the Missouri Rx plan and the federal Medicare Part D drug benefit program established by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), P.L. 108-173 and enrolls individuals in the program.

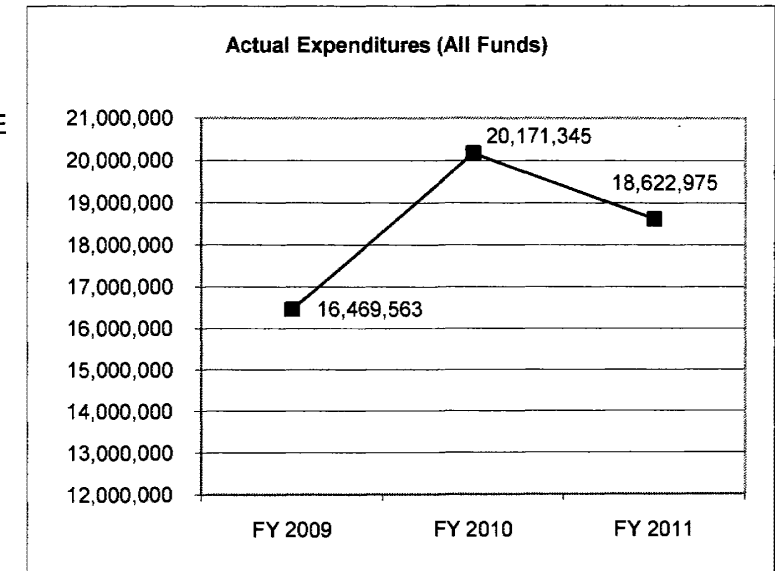
## 3. PROGRAM LISTING (list programs included in this core funding)

Pharmacy services under MMA - Part D

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.	
Appropriation (All Funds)	19,602,166	21,971,345	19,602,166	19,602,166	E
Less Reverted (All Funds)	0	(1,800,000)	0	N/A	
Budget Authority (All Funds)	19,602,166	20,171,345	19,602,166	N/A	
Actual Expenditures (All Funds)	16,469,563	20,171,345	18,622,975	N/A	
Unexpended (All Funds)	3,132,603	0	979,191	N/A	
Unexpended, by Fund:					
General Revenue	0	0	0	N/A	
Federal	0	0	0	N/A	
Other	3,132,603	0	979,191	N/A	

(1)



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

Estimated "E" appropriation for MO RX Plan fund appropriation.

(1) "E" increase of \$2,369,179 in Missouri Rx Plan Fund.



**CORE RECONCILIATION DETAIL**

**DEPARTMENT OF SOCIAL SERVICES**

**MISSOURI RX PLAN**

**5. CORE RECONCILIATION DETAIL**

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
<b>TAFP AFTER VETOES</b>							
	EE	0.00	0	0	26,600	26,600	
	PD	0.00	0	0	19,575,566	19,575,566	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>19,602,166</b>	<b>19,602,166</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	EE	0.00	0	0	26,600	26,600	
	PD	0.00	0	0	19,575,566	19,575,566	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>19,602,166</b>	<b>19,602,166</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	EE	0.00	0	0	26,600	26,600	
	PD	0.00	0	0	19,575,566	19,575,566	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>19,602,166</b>	<b>19,602,166</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>MISSOURI RX PLAN</b>								
<b>CORE</b>								
TRAVEL, IN-STATE	0	0.00	1,000	0.00	1,000	0.00	0	0.00
PROFESSIONAL SERVICES	0	0.00	25,500	0.00	25,500	0.00	0	0.00
BUILDING LEASE PAYMENTS	0	0.00	100	0.00	100	0.00	0	0.00
TOTAL - EE	0	0.00	26,600	0.00	26,600	0.00	0	0.00
PROGRAM DISTRIBUTIONS	18,622,975	0.00	19,575,566	0.00	19,575,566	0.00	0	0.00
TOTAL - PD	18,622,975	0.00	19,575,566	0.00	19,575,566	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$18,622,975</b>	<b>0.00</b>	<b>\$19,602,166</b>	<b>0.00</b>	<b>\$19,602,166</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00
OTHER FUNDS	\$18,622,975	0.00	\$19,602,166	0.00	\$19,602,166	0.00		0.00

## PROGRAM DESCRIPTION

Department: Social Services

Program Name: Missouri Rx Plan

Program is found in the following core budget(s): Missouri Rx Plan

### 1. What does this program do?

*PROGRAM SYNOPSIS: Pharmacy benefit program for Medicare/Medicaid dual eligibles and certain elderly and disabled below 200% of Federal Poverty Level (FPL), which provides a wrap around benefit for those enrolled in Medicare's (Part D) prescription drug program.*

S.B. 539 (2005) established a state pharmaceutical assistance program known as the Missouri Rx (MoRx) Plan. The purpose of this program is to coordinate pharmaceutical benefits between the Missouri Rx plan and the federal Medicare Part D drug program for Medicare/Medicaid full dual eligibles, partial duals and other elderly and disabled Missourians below 200% of FPL. The Missouri Rx plan pays 50% of members' out of pocket costs remaining after their Medicare Prescription Drug Plan pays. Missouri Rx pays for 50% of the deductible, 50% of the co-pays before the coverage gap, 50% of the coverage gap and 50% of the co-pays in the catastrophic coverage.

MoRx works with all Medicare Part D plans, but has a preferred relationship with three Medicare Part D plans to provide members with the best possible prescription drug coverage. The preferred plans provide MoRx members with high quality, affordable prescription drug coverage by offering easier access to a broader drug formulary with fewer medication restrictions.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.780 through 208.798; Federal law: Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173.

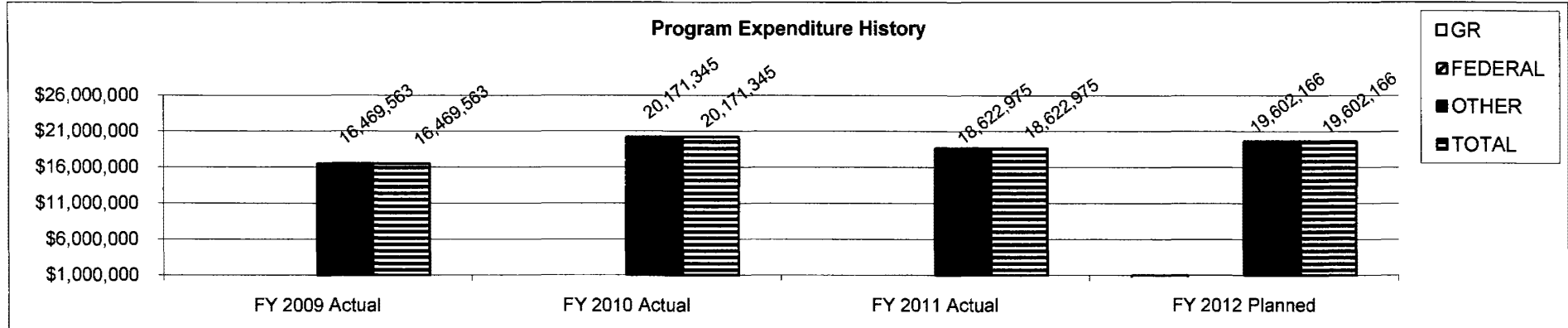
### 3. Are there federal matching requirements? If yes, please explain.

No. This program is funded with 100% state sources.

### 4. Is this a federally mandated program? If yes, please explain.

No.

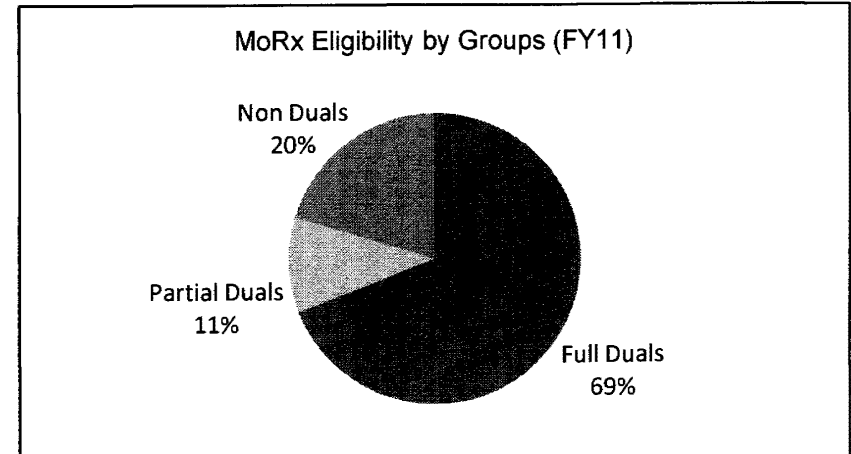
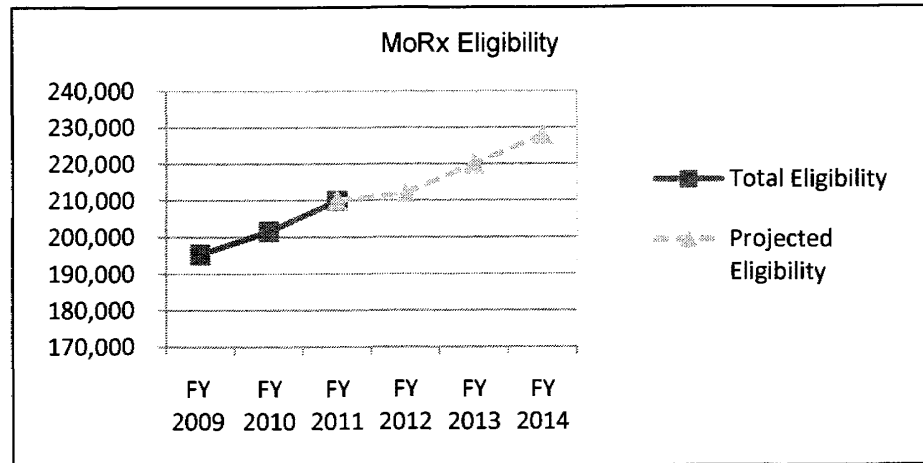
**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



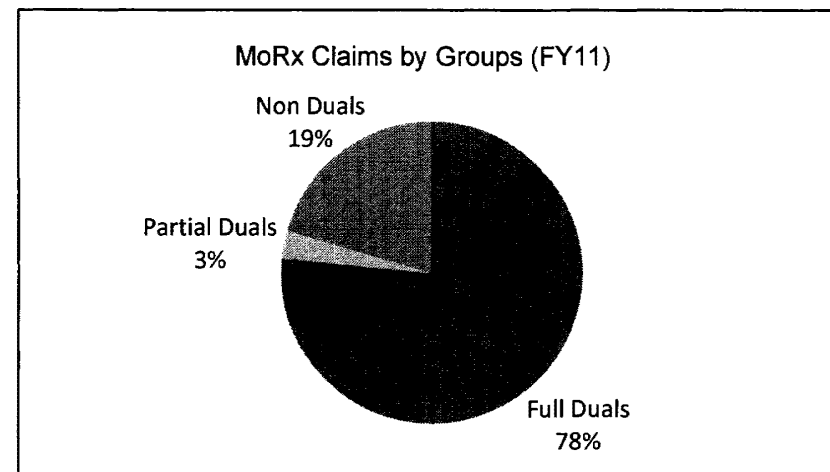
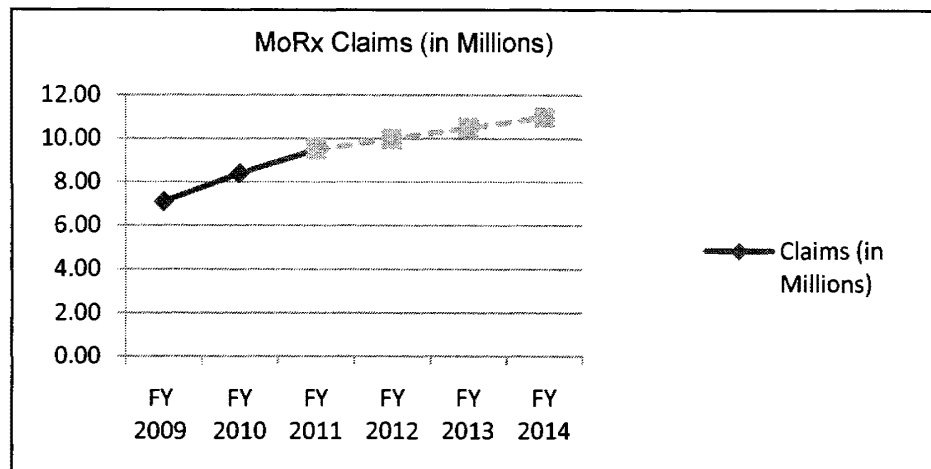
**6. What are the sources of the "Other " funds?**

Missouri Rx Plan Fund (0779) and Healthy Families Trust Fund (0625).

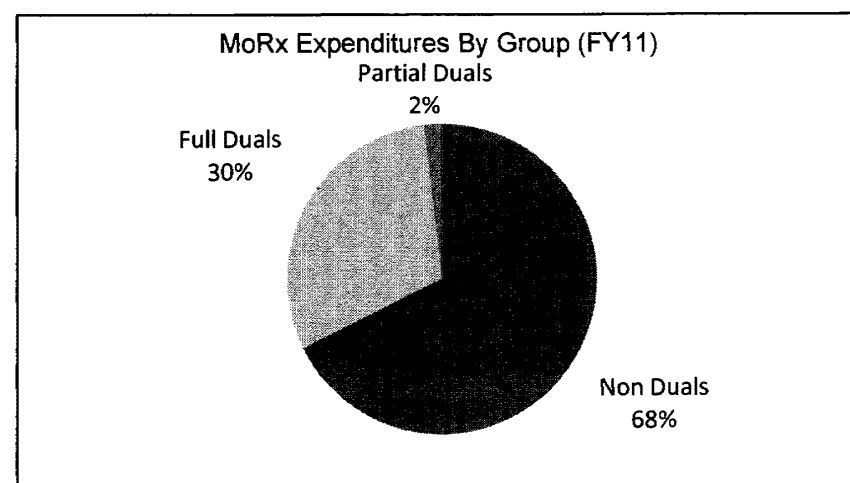
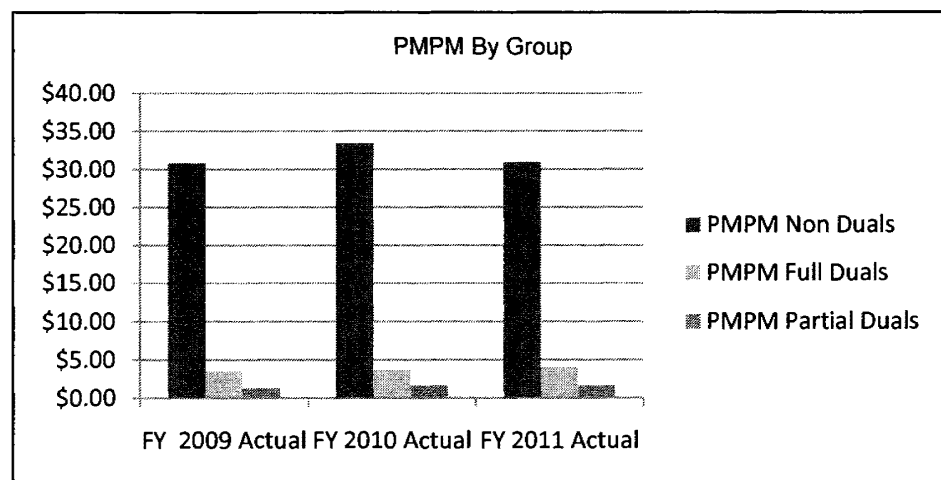
**7a. Provide an effectiveness measure.**



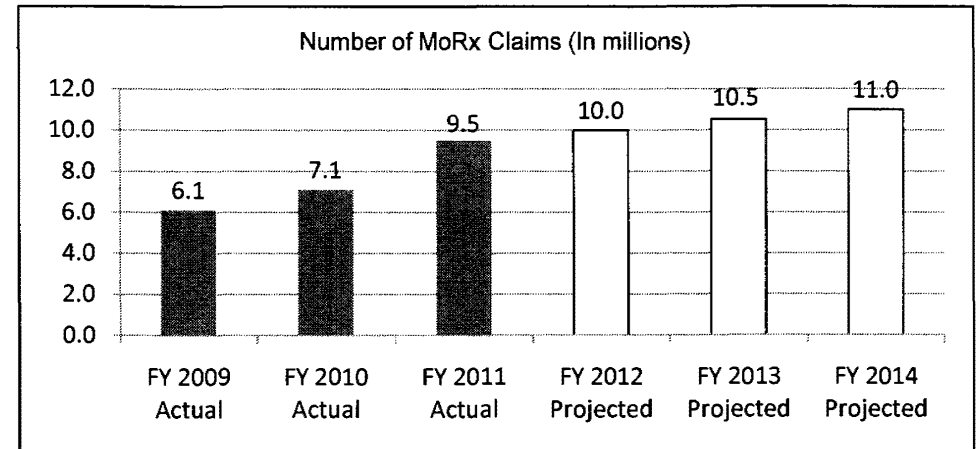
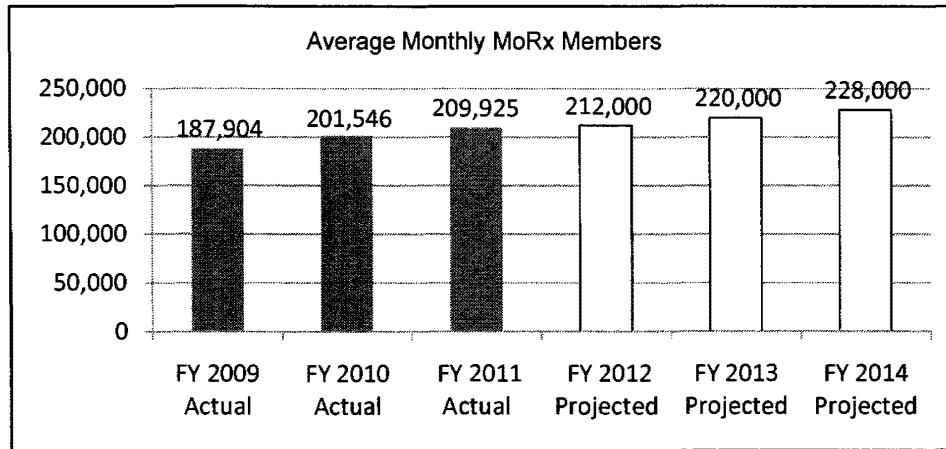
Full and partial dual eligibles receive the federal governments full "extra help" with Part D prescription drug costs. The MoRx's 50% benefit for these members was \$3.15 or less for each prescription for calendar year 2011. In contrast, 80% of the Non Duals do not qualify for the federal government's "extra help", so that the MoRx benefit is more substantial for them.



**7b. Provide an efficiency measure.**



**7c. Provide the number of clients/individuals served, if applicable.**



**7d. Provide a customer satisfaction measure, if available.**

# **Pharmacy FRA**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PHARMACY FRA								
CORE								
PROGRAM-SPECIFIC								
PHARMACY REIMBURSEMENT ALLOWAN	91,127,486	0.00	90,308,926	0.00	90,308,926	0.00	0	0.00
TOTAL - PD	91,127,486	0.00	90,308,926	0.00	90,308,926	0.00	0	0.00
TOTAL	91,127,486	0.00	90,308,926	0.00	90,308,926	0.00	0	0.00
GRAND TOTAL	\$91,127,486	0.00	\$90,308,926	0.00	\$90,308,926	0.00	\$0	0.00

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# CORE DECISION ITEM

Department: Social Services  
 Division: MO HealthNet  
 Core: Pharmacy Federal Reimbursement Allowance (PFRA) Payments

Budget Unit: 90542C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD			90,308,926	90,308,926
TRF				
Total			90,308,926	90,308,926
FTE			0.00	

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Pharmacy Reimbursement Allowance Fund (0144)

Note: An "E" is requested for the Pharmacy Reimbursement Allowance Fund.

## 2. CORE DESCRIPTION

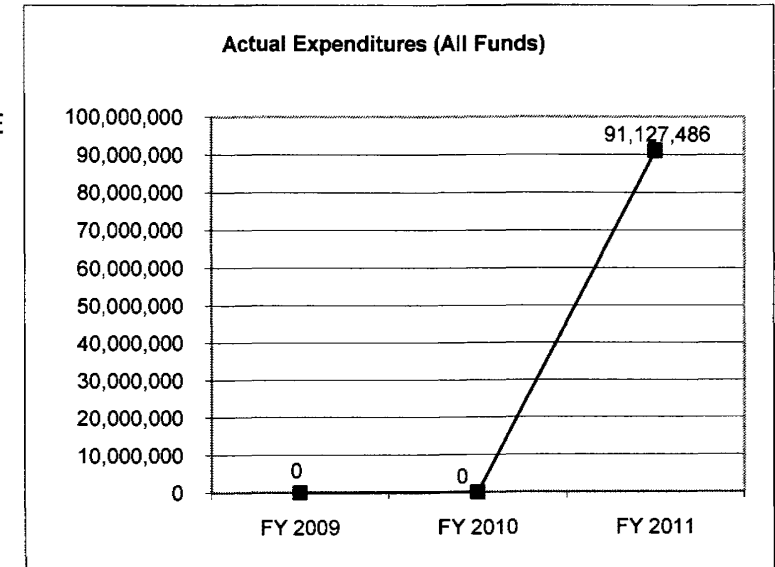
This core request is for ongoing funding for payments for pharmacy services for Title XIX participants. Funds from this core are used to provide enhanced dispensing fee payment rates using the Pharmacy Federal Reimbursement Allowance under the Title XIX of the Social Security Act as a General Revenue equivalent. Pharmacies are assessed a provider tax for the privilege of doing business in the state. The assessment is a general revenue equivalent, and when used to make valid Medicaid payments, earns federal dollars. These earnings fund this PFRA program appropriation and the Pharmacy appropriation.

## 3. PROGRAM LISTING (list programs included in this core funding)

Pharmacy Federal Reimbursement Allowance (PFRA) Program

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)			95,589,155	90,308,926 E
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	0	0	95,589,155	N/A
Actual Expenditures (All Funds)	0	0	91,127,486	N/A
Unexpended (All Funds)	0	0	4,461,669	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	0	0	0	N/A
Other	0	0	4,461,669	N/A
	(1)	(1)	(2)	



#### NOTES:

Estimated "E" appropriation for Pharmacy Reimbursement Allowance fund appropriation.

(1) The PFRA program was funded through the Pharmacy appropriation prior to FY11.

(2) "E" increase of \$5,280,229 Pharmacy Reimbursement Allowance Fund.

**CORE RECONCILIATION DETAIL**

**DEPARTMENT OF SOCIAL SERVICES**  
**PHARMACY FRA**

**5. CORE RECONCILIATION DETAIL**

	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	0	0	90,308,926	90,308,926	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>90,308,926</b>	<b>90,308,926</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	0	0	90,308,926	90,308,926	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>90,308,926</b>	<b>90,308,926</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	0	0	90,308,926	90,308,926	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>90,308,926</b>	<b>90,308,926</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PHARMACY FRA								
CORE								
PROGRAM DISTRIBUTIONS	91,127,486	0.00	90,308,926	0.00	90,308,926	0.00	0	0.00
TOTAL - PD	91,127,486	0.00	90,308,926	0.00	90,308,926	0.00	0	0.00
GRAND TOTAL	\$91,127,486	0.00	\$90,308,926	0.00	\$90,308,926	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00
OTHER FUNDS	\$91,127,486	0.00	\$90,308,926	0.00	\$90,308,926	0.00		0.00

## PROGRAM DESCRIPTION

**Department:** Social Services

**Program Name:** Pharmacy Federal Reimbursement Allowance (PFRA) Payments

**Program is found in the following core budget(s):** Pharmacy Federal Reimbursement Allowance (PFRA)

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides enhanced dispensing payments.*

Pharmacies are assessed a provider tax for the privilege of doing business in the state. The assessment is a general revenue equivalent, and when used to make valid Medicaid payments, earns federal dollars. These earnings fund the PFRA program. This program provides funding to pay enhanced dispensing fees to pharmacies using the Pharmacy Federal Reimbursement Allowance Fund as a General Revenue equivalent.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 338.500; Federal law: Social Security Act Section 1903(w); Federal Regulation: 42 CFR 433 Subpart B

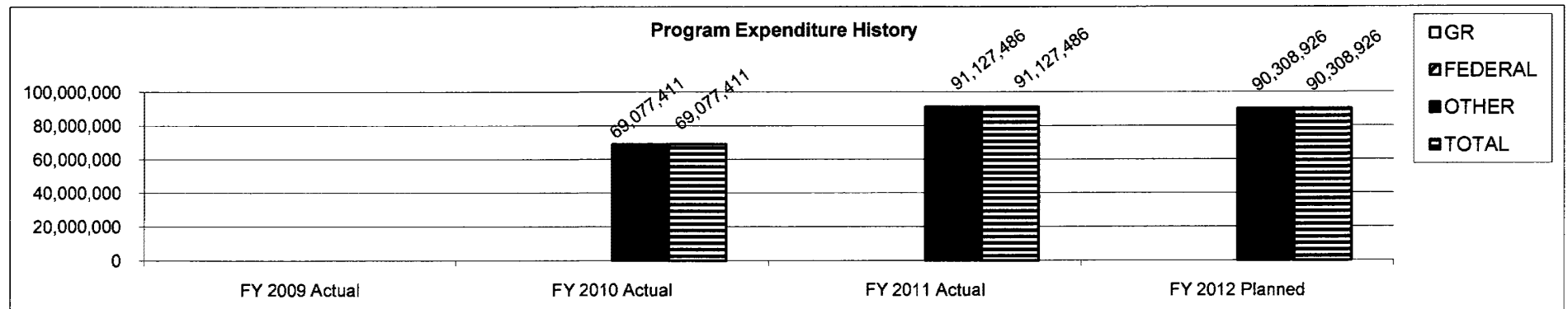
### 3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 is a blended 63.41% federal match. The state matching requirement is 36.59%.

### 4. Is this a federally mandated program? If yes, please explain.

No.

### 5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



The PFRA was requested as a new section in FY11. Previous expenditures are included in the Pharmacy program expenditure history.

**6. What are the sources of the "Other " funds?**

Pharmacy Federal Reimbursement Allowance (0144)

**7a. Provide an effectiveness measure.****7b. Provide an efficiency measure.**

Pharmacy FRA Tax Assessments Revenues Obtained to Draw Federal Dollars	
SFY	Assessments
2008	\$40.5 mil
2009	\$39.8 mil
2010	\$67.9 mil
2011	\$99.0 mil
2012	\$99.3 mil estimated
2013	\$99.3 mil estimated

**7c. Provide the number of clients/individuals served, if applicable.****7d. Provide a customer satisfaction measure, if available.**

**Physician Related**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>PHYSICIAN RELATED PROF</b>								
<b>CORE</b>								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	3,040,076	0.00	2,700,000	0.00	2,700,000	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	2,800,399	0.00	2,800,000	0.00	2,800,000	0.00	0	0.00
TOTAL - EE	5,840,475	0.00	5,500,000	0.00	5,500,000	0.00	0	0.00
PROGRAM-SPECIFIC								
GENERAL REVENUE	191,575,121	0.00	204,923,449	0.00	204,923,449	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	369,546,741	0.00	391,212,708	0.00	391,212,708	0.00	0	0.00
THIRD PARTY LIABILITY COLLECT	1,597,123	0.00	1,906,107	0.00	1,906,107	0.00	0	0.00
HEALTH INITIATIVES	1,210,118	0.00	1,247,544	0.00	1,247,544	0.00	0	0.00
HEALTHY FAMILIES TRUST	1,041,034	0.00	1,041,034	0.00	1,041,034	0.00	0	0.00
TOTAL - PD	564,970,137	0.00	600,330,842	0.00	600,330,842	0.00	0	0.00
<b>TOTAL</b>	<b>570,810,612</b>	<b>0.00</b>	<b>605,830,842</b>	<b>0.00</b>	<b>605,830,842</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Caseload Growth - 1886006</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	2,480,771	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	4,184,386	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	6,665,157	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>6,665,157</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Medicaid Primary Care Rate Inc - 1886016</b>								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	35,394,115	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	35,394,115	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>35,394,115</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$570,810,612</b>	<b>0.00</b>	<b>\$605,830,842</b>	<b>0.00</b>	<b>\$647,890,114</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

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# CORE DECISION ITEM

Department: Social Services

Budget Unit: 90544C

Division: MO HealthNet

Core: Physician, Nurse Practitioner, and Related Professionals

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE	2,700,000	2,800,000		5,500,000
PSD	204,923,449	391,212,708	4,194,685	600,330,842
TRF				
Total	<b>207,623,449</b>	<b>394,012,708</b>	<b>4,194,685</b>	<b>605,830,842</b>

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				

FTE

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Third Party Liability Collections Fund (TPL) (0120)

Health Initiatives Fund (HIF) (0275)

Healthy Families Trust Fund (0625)

## 2. CORE DESCRIPTION

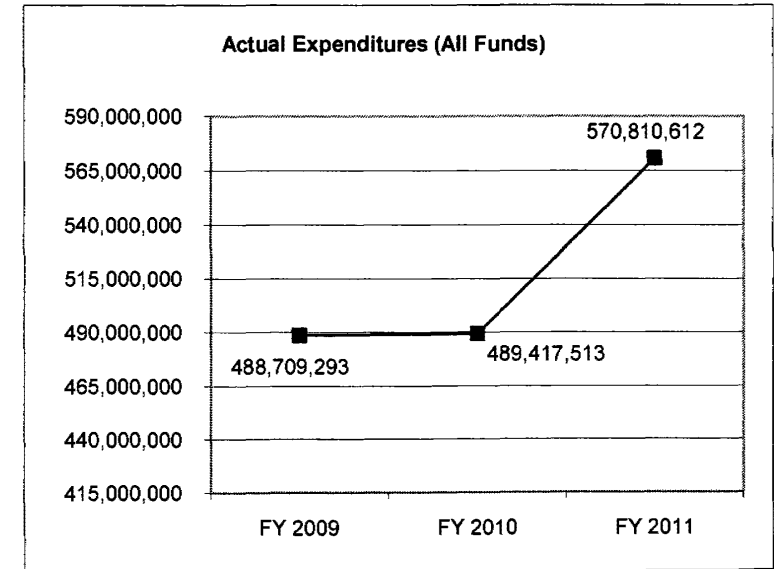
This core request is for the ongoing funding for professional services provided to MO HealthNet participants by physicians, nurse practitioners, clinics, lab and x-ray facilities, nurse midwives, podiatrists, certified registered nurse anesthetists, anesthesiologist assistants, independent diagnostic testing facilities, rural health clinics, federally qualified health centers, psychologists, professional counselors, and licensed clinical social workers.

## 3. PROGRAM LISTING (list programs included in this core funding)

Physician, nurse practitioner and other related professionals.

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2011 Current Yr
Appropriation (All Funds)	488,755,007	492,805,063	594,571,350	605,830,842
Less Reverted (All Funds)	(37,426)	(1,237,426)	(37,426)	N/A
Budget Authority (All Funds)	488,717,581	491,567,637	594,533,924	N/A
Actual Expenditures (All Funds)	488,709,293	489,417,513	570,810,612	N/A
Unexpended (All Funds)	8,288	2,150,124	23,723,312	N/A
Unexpended, by Fund:				
General Revenue	3,151	11	11,753,760	N/A
Federal	5,137	2,150,113	11,660,568	N/A
Other	0	0	308,984	N/A
	(1)	(2) (3)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

(1) Expenditures of \$22,501,730 were paid from the Supplemental Pool.

(2) Expenditures of \$89,692,366 were paid from the Supplemental Pool. Used \$3,064 in General Revenue to pay DESE services.

(3) Agency reserve of \$2,150,084 in Federal Fund.

#### 4. FINANCIAL HISTORY

Cost Per Eligible - Per Member Per Month (PMPM)					
	Physician PMPM***	Acute Care PMPM	Total PMPM	Physician Percentage of Acute	Physician Percentage of Total
PTD	\$139.72	\$953.39	\$1,579.47	14.66%	8.85%
Seniors	\$53.16	\$332.63	\$1,293.02	15.98%	4.11%
Custodial Parents	\$37.31	\$403.27	\$416.87	9.25%	8.95%
Children**	\$14.80	\$232.18	\$251.39	6.37%	5.89%
Pregnant Women	\$114.33	\$507.64	\$515.09	22.52%	22.20%

\* Claims only from FY 11 Table 23 Medical Statistics.  
 \*\* CHIP eligibles not included  
 \*\*\* Includes EPSDT services

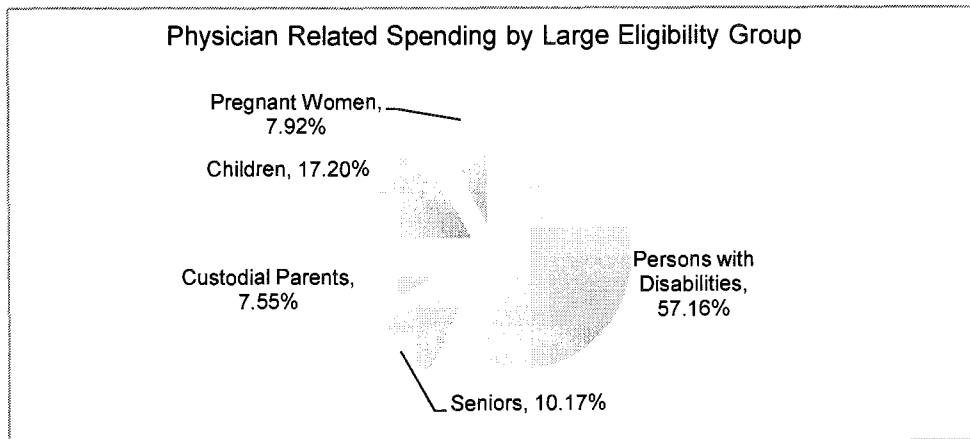
The Cost per Eligible - Per Member Per Month (PMPM) table provides the total PMPM for each large eligibility group. Health care entities use per member per month calculations as a benchmark to monitor, assess, and manage health care costs. The PMPM metric provides MHD management with a high level aggregate spending metric.

PMPM is calculated by dividing costs by the number of eligibles enrolled. Since caseload growth is accounted for when determining PMPM, the PMPM provides management with a better tool than just comparing overall increases in spending.

PMPM by eligibility group and type of service serves as a baseline for management to determine if cost control interventions are working as intended. Monitoring PMPM amounts allow tracking by a population so that a shift in services is reflected in one metric.

The PMPM table reflects the PMPM amounts for physician related services, acute care, and total. The acute care PMPM is made up of payments for the following services: inpatient, physician/lab/x-ray, outpatient/clinic, pharmacy, managed care payments, Medicare co-pay/deductibles, dental and other acute services administered by MHD. It does **not** include nursing facilities, in-home services, mental health services and state institutions. By comparing the physician PMPM to the acute care PMPM, MHD management can monitor the progress of interventions controlled by MHD management.

The Spending by Large Eligibility Group (left) shows the percentage of spending by each eligibility group for physician related services. It provides a snapshot of what eligibility groups are receiving physician related services, as well as the populations impacted by program changes.



Source: Table 23 Medical Statistics for Fiscal Year 2011

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES**

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**PHYSICIAN RELATED PROF**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	EE	0.00	2,700,000	2,800,000	0	5,500,000	
	PD	0.00	204,923,449	391,212,708	4,194,685	600,330,842	
	<b>Total</b>	<b>0.00</b>	<b>207,623,449</b>	<b>394,012,708</b>	<b>4,194,685</b>	<b>605,830,842</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	EE	0.00	2,700,000	2,800,000	0	5,500,000	
	PD	0.00	204,923,449	391,212,708	4,194,685	600,330,842	
	<b>Total</b>	<b>0.00</b>	<b>207,623,449</b>	<b>394,012,708</b>	<b>4,194,685</b>	<b>605,830,842</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	EE	0.00	2,700,000	2,800,000	0	5,500,000	
	PD	0.00	204,923,449	391,212,708	4,194,685	600,330,842	
	<b>Total</b>	<b>0.00</b>	<b>207,623,449</b>	<b>394,012,708</b>	<b>4,194,685</b>	<b>605,830,842</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PHYSICIAN RELATED PROF								
CORE								
PROFESSIONAL SERVICES	3,891,629	0.00	5,499,998	0.00	3,900,002	0.00	0	0.00
MISCELLANEOUS EXPENSES	1,948,846	0.00	2	0.00	1,599,998	0.00	0	0.00
TOTAL - EE	5,840,475	0.00	5,500,000	0.00	5,500,000	0.00	0	0.00
PROGRAM DISTRIBUTIONS	564,970,137	0.00	600,330,842	0.00	600,330,842	0.00	0	0.00
TOTAL - PD	564,970,137	0.00	600,330,842	0.00	600,330,842	0.00	0	0.00
GRAND TOTAL	\$570,810,612	0.00	\$605,830,842	0.00	\$605,830,842	0.00	\$0	0.00
GENERAL REVENUE	\$194,615,197	0.00	\$207,623,449	0.00	\$207,623,449	0.00		0.00
FEDERAL FUNDS	\$372,347,140	0.00	\$394,012,708	0.00	\$394,012,708	0.00		0.00
OTHER FUNDS	\$3,848,275	0.00	\$4,194,685	0.00	\$4,194,685	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Physician, Nurse Practitioner, and Related Professionals**

**Program is found in the following core budget(s): Physician Related**

### 1. What does this program do?

*PROGRAM SYNOPSIS: This program provides payment for professional services provided to MO HealthNet participants by physicians, clinics, lab & x-ray facilities, nurse midwives, podiatrists, certified registered nurse anesthetists, anesthesiologist assistants, independent diagnostic testing facilities, rural health clinics, nurse practitioners, federally qualified health centers, psychologists, professional counselors, and licensed clinical social workers.*

A general description of each of the MO HealthNet provider groups in the Physician Related Program includes the following:

Physician - Proper health care is essential to the general health and well-being of MO HealthNet participants. Physicians, including medical doctors and doctors of osteopathy, are typically the front line providers where MO HealthNet participants enter the state's health care system. They provide a myriad of health care services and tie the various parts of the health care system together.

Physician services are diagnostic, therapeutic, rehabilitative or palliative procedures provided by, and under the supervision of, a licensed physician who is practicing within the scope of practice allowed and is enrolled in the MO HealthNet program.

Physicians enrolled in the MO HealthNet program are identified by the specialty of medicine they practice. Specialties include: allergy immunology; anesthesiology; dermatology; emergency medicine; family practice; general practice; general surgery; internal medicine; laryngology; nuclear medicine; neurological surgery; obstetrics/gynecology; ophthalmology; otology; otolaryngology; orthopedic surgery; pathology; pediatrics; physical medicine and rehabilitation; plastic surgery; preventive medicine; proctology; psychiatry; neurology; radiation therapy; radiology; rectal and colon surgery; rehabilitative medicine; rhinology; thoracic surgery; urology; and cardiology.

The services of a physician may be administered in a myriad of settings including the physician's office, the participant's home (or other place of residence such as a nursing facility), the hospital (inpatient/outpatient) or settings such as a medical clinic or ambulatory surgical care facility.

Services rendered by a physician, including appropriate supplies, are billable by the physician only where there is direct personal supervision by the physician. This applies to services rendered by auxiliary personnel employed by the physician and working under his/her on-site supervision such as nurses, non-physician anesthetists, physician assistants, technicians, therapists and other aides.

The majority of services provided by a physician are reimbursed on a fee schedule basis although a few services are reimbursed on a manual basis, whereby each procedure or claim is priced individually by a medical consultant based on the unique circumstances of the case. Certain procedures, such as organ transplants, are available only on a prior approval basis.

Periodic Screening Diagnosis Treatment /Healthy Children and Youth (EPSDT/HCY) program provides services to MO HealthNet participants who are infants, children, and youth under the age of 21 years with a primary and preventive care focus. Full, partial and interperiodic health screenings, medical and dental examinations, immunizations and medically necessary treatment services are covered. The goal of the MO HealthNet program is for each child to be healthy. This is achieved by the primary care provider who manages a coordinated, comprehensive, continuous health care program to address the child's primary health care needs. The program provides early and periodic medical or dental screening, diagnosis, and treatment to correct or improve defects and chronic conditions found during the screening.

Clinic - Clinics offer preventive, diagnostic, therapeutic, rehabilitative or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Services furnished to outpatients include those furnished at the clinic by, or under the direction of, a physician and those services furnished outside the clinic by clinic personnel under the direction of a physician.

MO HealthNet reimbursement is made solely to the clinic. All health care professionals are employed by the clinic. Each provider of health care services through the clinic, in addition to being employed by the participating clinic, must be a MO HealthNet provider. Health care providers at a clinic can include physicians, nurse practitioners, radiologists and other health professionals whose services are offered at the clinic.

Lab & X-Ray - Laboratory and x-ray facilities provide examination and radiology services under the Physician program. Laboratories perform examinations of body fluids, tissues or organs by the use of various methods employing specialized equipment such as electron microscopes and radio-immunoassay. A clinical laboratory is a laboratory where microbiological, serological, chemical, hematological, radio bioassay, cytological, immunohematological or pathological examinations are performed on material derived from the human body to provide information for the diagnosis, prevention or treatment of a disease or assessment of a medical condition. Operations of a laboratory are generally directed by a pathologist.

X-ray facilities offer radiological services in which x-rays or rays from radioactive substances are used for diagnostic or therapeutic purposes. Such services include, but are not limited to radium therapy; the use of radioisotopes for diagnostic or therapeutic purposes for example, in nuclear medicine; diagnostic tests such as aortograms, pyelograms, myelograms, arteriograms and ventriculograms; imaging services; x-rays; and diagnostic ultra-sounds. These operations are generally directed by a radiologist.

Both laboratories and x-ray clinics are reimbursed on a fee schedule basis. Certain x-ray services are subject to prior approval.

Nurse Midwife - Nurse Midwife services are those services related to the management and provision of care to a pregnant woman and her unborn/newborn infant by a certified nurse midwife. These services may be provided throughout the maternity cycle which includes pregnancy, labor and delivery and the initial postpartum period not to exceed six weeks. Covered services include antepartum care, delivery, post-partum care, newborn care, office visits, laboratory services and other services within the scope of practice of a nurse midwife. If there is any indication the maternity care is not for a normal uncomplicated delivery, the nurse midwife must refer the case to a physician.

Nurse midwives may also provide care outside of the maternity cycle such as family planning, counseling, birth control techniques and well-woman gynecological care including routine pap smears and breast examinations (Section 13605, OBRA 93). Nurse midwife services may also include services to the newborn, age 0 through 2 months and any other MO HealthNet eligible female, age 15 and over.

Services furnished by a nurse midwife must be within the scope of practice authorized by federal and state laws or regulations and, in the case of inpatient or outpatient hospital services or clinic services, furnished by or under the direction of a nurse midwife only to the extent permitted by the facility.

In order to qualify for participation in the MO HealthNet Nurse Midwife program, in addition to provisions required of all MO HealthNet providers, the applicant must hold a valid current license as an advanced practice nurse (RN) in the state of Missouri and be currently certified as a nurse midwife by the American College of Nurse Midwives.

The services of a nurse midwife may be administered in a variety of settings including the provider's office, a hospital (inpatient or outpatient), the home of the participant (delivery and newborn care only) or a birthing center. Reimbursement for nurse midwife services is made on a fee-for-service basis and must be reasonable and consistent with efficiency, economy and quality of care as determined by MO HealthNet. MO HealthNet payment is the lower of the provider's actual billed charge, based on his/her usual and customary charge to the general public for the service, or the MO HealthNet maximum allowable amount per unit of service. The level of reimbursement to the nurse midwife is the same as that reimbursed to a physician for the same procedure.

Podiatry - Podiatrists provide medical, surgical and mechanical services for the foot or any area not above the ankle joint and receive MO HealthNet reimbursement for diagnostic, therapeutic, rehabilitative and palliative services which are within the scope of practice the podiatrist is authorized to perform. Most services provided by a podiatrist are reimbursed on a fee schedule basis although a few services are reimbursed on a manual basis, whereby each procedure or claim is priced individually by a medical consultant based on the unique circumstances of the case.

The following podiatry services are not covered for adults (except individuals under a category of assistance for pregnant women or the blind or nursing facility residents): trimming of nondystrophic nails; debridement of one to five nails by any method; debridement of six or more nails by any method; partial or complete excision of the nail and nail matrix; and strapping of the ankle and/or foot.

The services of a podiatrist may be administered in the podiatrist's office, the participant's home (or other place of residence such as a nursing facility), a hospital (inpatient/outpatient), a medical clinic or ambulatory surgical care facility.

Certified Registered Nurse Anesthetist (CRNA) - CRNA services are those services related to the introduction and management of a substance into the body by external or internal means that causes loss of sensation with or without loss of consciousness. In order to qualify for participation in the MO HealthNet Certified Registered Nurse Anesthetist program, in addition to provisions required of all MO HealthNet providers, the applicant must hold a valid current license as an advanced practice nurse (RN) or nurse practitioner in the state of Missouri and be currently certified as a CRNA by the Council on Certification of Nurse Anesthetists.

Reimbursement for CRNA services are made on a fee-for-service basis. The services of a CRNA may be administered in the providers' office, a hospital, nursing home or clinic and include the same scope of practice as that of an anesthesiologist. CRNAs are often employed by physicians (anesthesiologists), but are not required to be employed by a physician.

Anesthesiologist Assistants (AA) - An AA is a person who works under the supervision of a licensed anesthesiologist and provides anesthesia services and related care. An AA shall practice only under the direct supervision of an anesthesiologist who is physically present or immediately available. A supervising anesthesiologist shall be allowed to supervise up to four AAs concurrently, consistent with 42 CFR 415.110. The name and mailing address of the supervising anesthesiologist must be submitted by an AA. An AA must be licensed by the Missouri Board of Healing Arts as set forth in 20 CSR 2150-9 and submit a copy to the MO HealthNet Division. An AA must practice within their scope of practice referenced in Section 334.402, RSMo. Reimbursement for AA services is made on a fee-for-service basis. An AA and a Certified Registered Nurse Anesthetist (CRNA) are not allowed to bill for the same anesthesia service.

Independent Diagnostic Testing Facility (IDTF) - These providers are independent of a hospital or a physician's office and offer medically necessary diagnostic tests. The IDTF may be a fixed location or a mobile entity. An IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the qualification of non-physician personnel who use the equipment.

Rural Health Clinic (RHC) - The Rural Health Clinic Services Act of 1977 designated Rural Health Clinics as health care providers. The Act became effective for MO HealthNet reimbursement on July 1, 1978. The Rural Health Clinic Services Act of 1977 extended benefits to cover health care services to under-served rural areas where access to traditional physician care had been difficult. In those areas, specifically trained practitioners furnish the health care services needed by the community.

Rural Health Clinics must be located in a rural area that is designated a shortage area for primary care. To be eligible for this designation, a clinic must be located in an area not identified as "urbanized" by the Bureau of the Census and designated as a shortage or under-served area by one of the following definitions:

- An area with a shortage of personal health services under Section 30(b)(3) or 330(b)(3) of the Public Health Service Act (PHS);
- A Health Professional Shortage Area (HPSA) designated under Section 332(a)(1)(A) of the PHS Act;
- An area which includes a population group designated as having a health professional shortage under Section 332(a)(1)(B) of the PHS Act; or
- An area designated by the chief executive officer (Governor) of the State and certified by the Secretary of Health and Human Services as an area with a shortage of personal health services.

In addition to the above criteria, RHCs must meet the additional staffing and health and safety requirements set forth by the Rural Health Clinic Services Act. To be a MO HealthNet RHC, a clinic must be certified by the Public Health Service, be certified for participation in Medicare, and be enrolled as a MO HealthNet provider. The RHC is then designated as either an independent or a provider-based RHC.



In order to be designated a provider-based RHC, the RHC must be an integral and subordinate part of a hospital, skilled nursing facility or home health agency. The provider-based RHC must also be under common licensure, governance and professional supervision with its parent provider. Hospital-based RHCs are reimbursed the lower of 100% of their usual and customary charges or their cost-to-charge ratio. The RHCs that are based in skilled nursing facilities and home health agencies are reimbursed their usual and customary charges multiplied by the lower of the Medicare RHC rate or the rate approved by the MO HealthNet Division.

An independent RHC has no financial, organizational or administrative connection to a hospital, skilled nursing facility or home health agency. They are reimbursed a fee that is calculated either by dividing the lesser of their reasonable costs by their total number of encounters, or by multiplying the Medicare upper- payment limit by the number of MO HealthNet encounters. An annual audit of the Medicare cost report is reviewed by the Institutional Reimbursement Unit (IRU) within the MO HealthNet Division.

**Nurse Practitioner** - A nurse practitioner, or advanced practice nurse, is one who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the Missouri Board of Nursing. The Board of Nursing may promulgate rules specifying which professional nursing organization certifications are to be recognized as advanced practice nurses and may set standards for education, training and experience required for those without such specialty certification to become advanced practice nurses.

Numerous nurse practitioner specialties are recognized such as family, gerontology, clinical, obstetrics/GYN, neonatal, mental health, and certified registered nurse anesthetists. Reimbursement for nurse practitioner services are made on a fee-for-service basis. The level of reimbursement to the nurse practitioner is the same as that reimbursed to a physician for the same procedure. Nurse practitioners, or advanced practical nurses may prescribe medications only through a collaborative agreement with a physician.

Nurse practitioner services involve the performance for compensation of any act which requires substantial specialized education, judgment, and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences, including: a) responsibility for the teaching of health care and the prevention of illness to the patient and his/her family; b) assessment, nursing diagnosis, nursing care, and counsel of persons who are ill, injured or experiencing alterations in normal health processes; c) administration of medications and treatments as prescribed by a person licensed in this state to prescribe such medications and treatments; and d) coordination and assistance in the delivery of a plan of health care with all members of the health team.

The services of a nurse practitioner may be administered in a variety of settings including the provider's office, a hospital, nursing home or clinic. Nurse practitioners are generally employed by physicians, but are not required to be employed by physicians.

**Federally Qualified Health Clinic (FQHC)** - The FQHC program was established by the Omnibus Budget Reconciliation Acts of 1989 (OBRA 89) and 1990 (OBRA 90). These laws designated certain community-based health care organizations as unique health care providers called Federally Qualified Health Centers. These laws establish a set of FQHC health care services that MO HealthNet and Medicare must cover for those beneficiaries who receive services from the FQHC and require the reimbursement of reasonable cost to the FQHC for such services.

By passing the FQHC legislation, Congress recognized the following two goals of the FQHC program:

- To provide adequate reimbursement to community-based primary health care organizations (FQHCs) so that they, in turn, may better serve large number of MO HealthNet participants and/or provide more services, thus improving access to primary care.
- To enable FQHCs to use other resources previously subsidizing MO HealthNet to serve uninsured individuals who, although not eligible for MO HealthNet, have a difficult time obtaining primary care because of economic or geographic barriers.

In order to qualify for FQHC status, a facility must receive or be eligible for a grant under Section 329, 330 or 340 of the Public Health Service Act, meet the requirements for receiving such a grant, or have been a Federally Funded Health Center as of January 1, 1990.

FQHC services are initially reimbursed at 97% of the billed MO HealthNet FQHC covered charges. An annual audit of the MO HealthNet cost report is performed by the Institutional Reimbursement Unit (IRU) to determine reasonable costs. A settlement is made to adjust the reimbursement to 100% of the reasonable costs to provide MO HealthNet FQHC covered services.

Health Homes - Section 2703 of the ACA gives MO HealthNet the option to pay providers to coordinate care through a "Health Home" for individuals with chronic conditions. A health home is a "designated provider" or a health team that provides health home services to an individual with a chronic condition. A "designated provider" can be a physician, clinical practice or clinical group practice, rural clinic, community health center, home health agency, or any other entity or provider that is determined by MO HealthNet and approved by the Secretary of Health and Human Services to be a qualified health home. A team of health care professionals acting as a health home may include physicians and other professionals such as a nurse care coordinator, nutritionist or social worker. Health homes may be freestanding, virtual, or based at a hospital or other facility. Health home services include comprehensive care management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings, patient and family support, and referral to community and social support services. Health homes are required to use "health information technology" to link services. Individuals who are eligible for health home services must have at least two chronic conditions or one chronic condition and the risk of having a second.

Pending CMS approval, DSS will make payment for start-up costs and lost productivity due to collaboration demands on staff not covered by other streams of payment. In addition, clinical care management per member per month (PMPM) payments will be made for the reimbursement of the cost of staff primarily responsible for delivery of services not covered by other reimbursement (Primary Care Nurses) whose duties are not otherwise reimbursable by MO HealthNet. Also, DSS will make payment to Practices for 50% of the value of the reduction in total health care PMPM cost, including the payments mentioned above, for the Practice Site's attributed MO HealthNet patients, relative to prior year experience.

Psychologists, Professional Counselors, and Licensed Clinical Social Workers - Medically necessary mental health services are available to MO HealthNet eligible children under the age of 21. Those services can be provided by psychologists, professional counselors and licensed clinical social workers. An adult may receive mental health services from a psychologist, but may only receive them from a licensed clinical social worker if they are a member of a FQHC or RHC. Licensed Professional Counselors may not provide services to adults in any setting.

Psychologists and provisionally licensed psychologists provide testing and assessment, individual, family and group therapy and crisis intervention services to children and adults.

Licensed Clinical Social Workers, provisionally Licensed Clinical Social Workers, Licensed Professional Counselors, and provisionally Licensed Professional Counselors provide assessment, individual, family and group therapy and crisis intervention services to children. Licensed Clinical Social Workers and provisionally Licensed Clinical Social Workers may also provide these services to adults in the FQHC or RHC setting.

**2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State statute: RSMo. 208.153, 208.166; Federal law: Social Security Act Sections 1905(a)(2), (3), (5), (6), (9), (17), (21); 1905(r) and 1915(d); Federal regulations: 42 CFR 440.210, 440.500, 412.113(c) and 441 Subpart B.

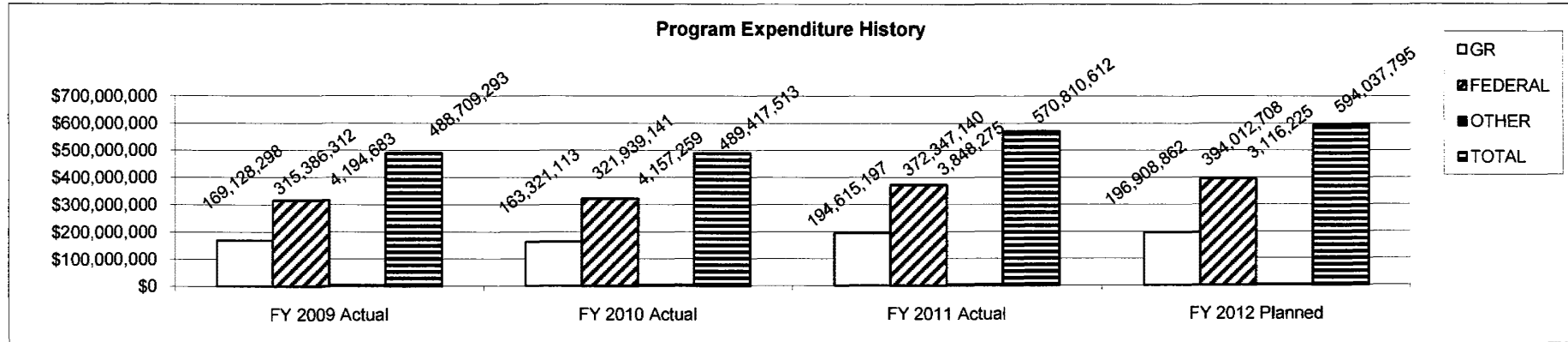
**3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 is a blended 63.41% federal match. The state matching requirement is 36.59%.

**4. Is this a federally mandated program? If yes, please explain.**

Yes, if the state elects to have a Medicaid program. (Some services are optional: podiatry, clinics, nurse practitioners and certified nurse anesthetist.)

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



Reverted: \$10,714,587 General Revenue; \$37,426 Other Funds  
Reserve: \$1,041,034 Other Funds

**6. What are the sources of the "Other " funds?**

Third Party Liability Collections Fund (0120), Health Initiatives Fund (0275) and Healthy Families Trust Fund (0625).

**7a. Provide an effectiveness measure.**

Effectiveness Measure: Increase the ratio of participants who receive EPSDT screenings. The ratio has increased by 3% a year over the last three years.

The Healthy Children and Youth (HCY) Program in Missouri is a comprehensive, primary and preventive health care program for MO HealthNet eligible children and youth under the age of 21 years. The program is also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT). The HCY Program provides early and periodic medical/dental screenings, diagnosis and treatment to correct or ameliorate defects and chronic conditions found during the screening.

EPSDT Participant Ratio			
*Federal Fiscal Year	Participants who should have received a screening	Participants who received at least one screening	Participant Ratio
2009	398,346	278,622	70%
2010	417,032	306,364	73%
2011	427,104	323,286	76%
**2012	437,419	341,142	78%
**2013	451,301	365,026	81%
**2014	463,341	386,986	84%

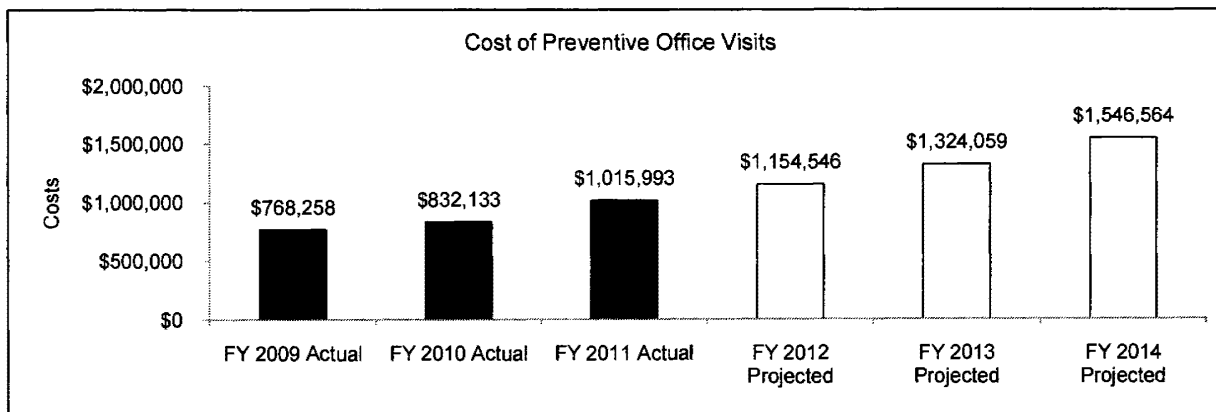
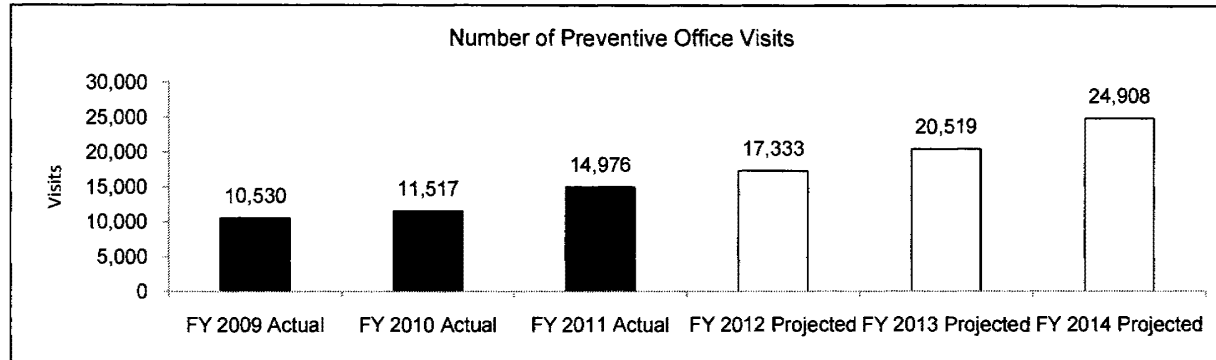
\*Based on federal fiscal year in which report was submitted to CMS.

\*\*Projected

**7b. Provide an efficiency measure.**

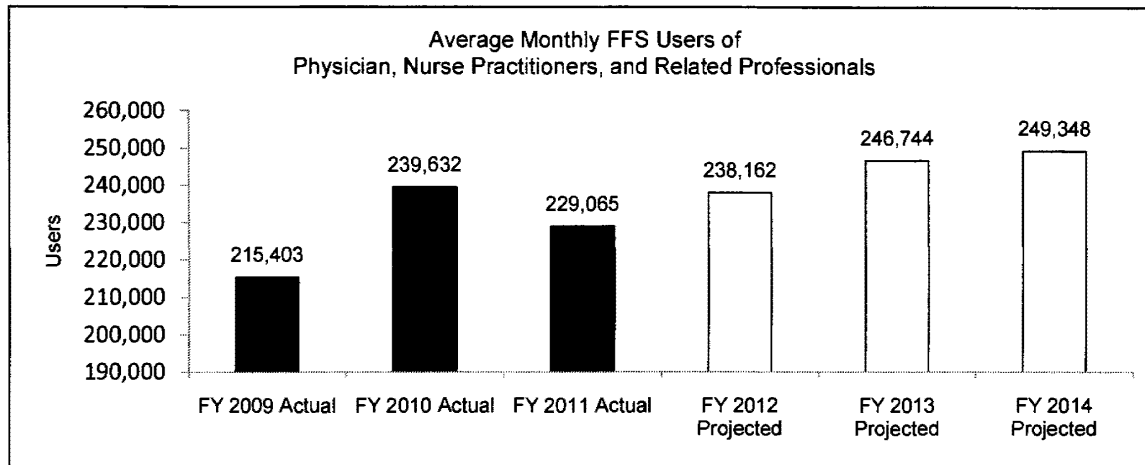
Efficiency Measure: Increase the number of adult preventive office visits. In state fiscal year 2011, the number of adult preventive office visits increased by 19% over the number in state fiscal year 2010.

MO HealthNet pays for one "preventive" examination/physical. Preventive visits are important for routine evaluation and management of adults for the maintenance of good health and a reduction in risk factors that could lead to more expensive health care costs.



**7c. Provide the number of clients/individuals served, if applicable.**

Proper health care is essential to the general health and well-being of MO HealthNet participants. Physician related services are typically the front line where MO HealthNet participants enter the state's health care system. Services are provided by physicians, psychologists, nurse practitioners, podiatrists, clinics, and x-ray and lab facilities.



**7d. Provide a customer satisfaction measure, if available.**

**Dental**

# FY13 Department of Social Services Report #9

# DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN	
DENTAL									
CORE									
PROGRAM-SPECIFIC									
GENERAL REVENUE	5,223,490	0.00	6,486,786	0.00	6,486,786	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	10,793,071	0.00	12,907,120	0.00	12,907,120	0.00	0	0.00	
HEALTH INITIATIVES	54,219	0.00	71,162	0.00	71,162	0.00	0	0.00	
HEALTHY FAMILIES TRUST	848,773	0.00	848,773	0.00	848,773	0.00	0	0.00	
TOTAL - PD	16,919,553	0.00	20,313,841	0.00	20,313,841	0.00	0	0.00	
TOTAL	16,919,553	0.00	20,313,841	0.00	20,313,841	0.00	0	0.00	
Caseload Growth - 1886006									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	60,914	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	102,746	0.00	0	0.00	
TOTAL - PD	0	0.00	0	0.00	163,660	0.00	0	0.00	
TOTAL	0	0.00	0	0.00	163,660	0.00	0	0.00	
GRAND TOTAL	\$16,919,553	0.00	\$20,313,841	0.00	\$20,477,501	0.00	\$0	0.00	

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Dental

Budget Unit: 90546C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	6,486,786	12,907,120	919,935	20,313,841
TRF				
Total	6,486,786	12,907,120	919,935	20,313,841
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Health Initiatives Fund (HIF) (0275)  
Healthy Families Trust Fund (0625)

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

## 2. CORE DESCRIPTION

This core request is for the continued funding of the dental fee-for-service program. Funding provides dental services for children, pregnant women, the blind, and nursing facility residents in the defined non-managed care MO HealthNet population.

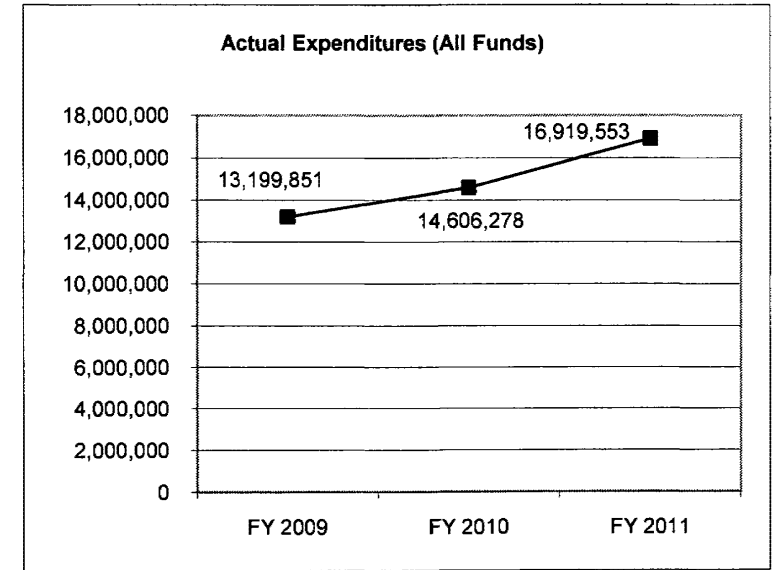
## 3. PROGRAM LISTING (list programs included in this core funding)

Dental Services



#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	13,201,986	14,608,413	19,914,360	20,313,841
Less Reverted (All Funds)	(2,135)	(2,135)	(2,135)	N/A
Budget Authority (All Funds)	13,199,851	14,606,278	19,912,225	N/A
Actual Expenditures (All Funds)	13,199,851	14,606,278	16,919,553	N/A
Unexpended (All Funds)	0	0	2,992,672	N/A
Unexpended, by Fund:				
General Revenue	0	0	1,076,985	N/A
Federal	0	0	1,900,879	N/A
Other	0	0	14,808	N/A
	(1)	(2)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

(1) Expenditures of \$1,902,556 were paid from the Supplemental Pool.

(2) Expenditures of \$2,523,921 were paid from the Supplemental Pool.

#### 4. FINANCIAL HISTORY

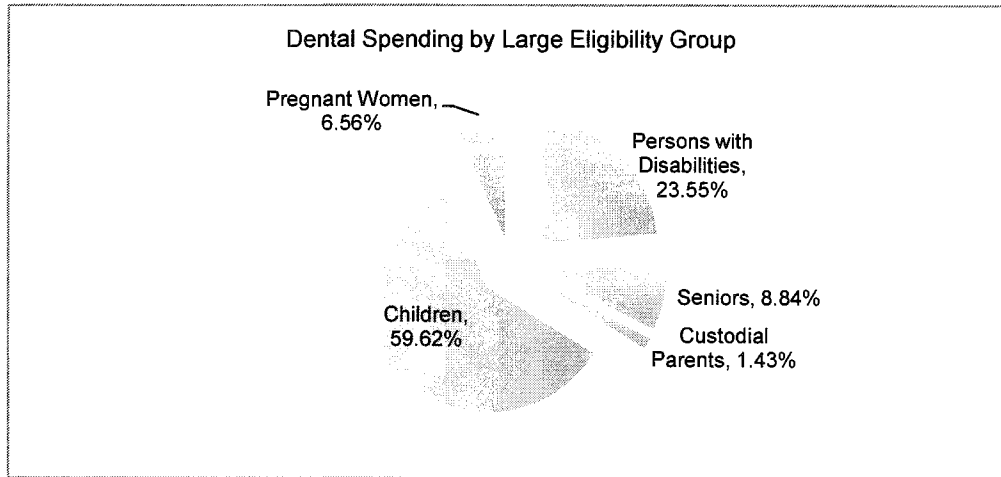
Cost Per Eligible - Per Member Per Month (PMPM)					
	Dental PMPM*	Acute Care PMPM	Total PMPM	Dental Percentage of Acute	Dental Percentage of Total
PTD	\$1.64	\$953.39	\$1,579.47	0.17%	0.10%
Seniors	\$1.31	\$332.63	\$1,293.02	0.39%	0.10%
Custodial Parents	\$0.20	\$403.27	\$416.87	0.05%	0.05%
Children**	\$1.46	\$232.18	\$251.39	0.63%	0.58%
Pregnant Women	\$2.69	\$507.64	\$515.09	0.53%	0.52%

\* Claims only from FY 11 Table 23 Medical Statistics.  
 \*\* CHIP eligibles not included

The Cost per Eligible - Per Member Per Month (PMPM) table provides the total PMPM for each large eligibility group. Health care entities use per member per month calculations as a benchmark to monitor, assess, and manage health care costs. The PMPM metric provides MHD management with a high level aggregate spending metric.

PMPM is calculated by dividing costs by the number of eligibles enrolled. Since caseload growth is accounted for when determining PMPM, the PMPM provides management with a better tool than just comparing overall increases in spending.

PMPM by eligibility group and type of service serves as a baseline for management to determine if cost control interventions are working as intended. Monitoring PMPM amounts allow tracking by a population so that a shift in services is reflected in one metric.



The PMPM table reflects the PMPM amounts for dental care, acute care, and total. The acute care PMPM is made up of payments for the following services: inpatient, physician/lab/x-ray, outpatient/clinic, drugs, managed care payments, Medicare co-pay/deductibles, dental and other acute services administered by MHD. It does **not** include nursing facilities, in-home services, mental health services and state institutions. By comparing the dental PMPM to the acute care PMPM, MHD management can monitor the progress of interventions controlled by MHD management.

The Spending by Large Eligibility Group (left) shows the percentage of spending by each eligibility group for dental services. It provides a snapshot of what eligibility groups are receiving the services, as well as the populations impacted by program changes.

Source: Table 23 Medical Statistics for Fiscal Year 2011

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES****DENTAL**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	6,486,786	12,907,120	919,935	20,313,841	
	<b>Total</b>	<b>0.00</b>	<b>6,486,786</b>	<b>12,907,120</b>	<b>919,935</b>	<b>20,313,841</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	6,486,786	12,907,120	919,935	20,313,841	
	<b>Total</b>	<b>0.00</b>	<b>6,486,786</b>	<b>12,907,120</b>	<b>919,935</b>	<b>20,313,841</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	6,486,786	12,907,120	919,935	20,313,841	
	<b>Total</b>	<b>0.00</b>	<b>6,486,786</b>	<b>12,907,120</b>	<b>919,935</b>	<b>20,313,841</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
DENTAL								
CORE								
PROGRAM DISTRIBUTIONS	16,919,553	0.00	20,313,841	0.00	20,313,841	0.00	0	0.00
TOTAL - PD	16,919,553	0.00	20,313,841	0.00	20,313,841	0.00	0	0.00
GRAND TOTAL	\$16,919,553	0.00	\$20,313,841	0.00	\$20,313,841	0.00	\$0	0.00
GENERAL REVENUE	\$5,223,490	0.00	\$6,486,786	0.00	\$6,486,786	0.00		0.00
FEDERAL FUNDS	\$10,793,071	0.00	\$12,907,120	0.00	\$12,907,120	0.00		0.00
OTHER FUNDS	\$902,992	0.00	\$919,935	0.00	\$919,935	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Dental**

**Program is found in the following core budget(s): Dental**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides payment for dental services for fee-for-service MO HealthNet participants eligible for dental services.*

Dental services are typically those diagnostic, preventive and corrective procedures provided by a licensed dentist or dental hygienist performing within his/her scope of practice. The dentist must be enrolled in the MO HealthNet program. Generally, dental services include: treatment of the teeth and associated structure of the oral cavity; preparation, fitting and repair of dentures and associated appliances; and treatment of disease, injury or impairments that affect the general oral health of a participant.

To participate in the MO HealthNet program, a dentist must be licensed by the Missouri Dental Board and have a signed Title XIX Participation Agreement. The services of a dentist may be administered in a variety of settings including the provider's office, a hospital, nursing home or clinic. The fees paid to the provider are based on maximum allowable amounts identified on a fee schedule. Prior authorization is required for certain services, such as orthodontic treatment, composite resin crowns, metallic and porcelain/ceramic inlay restorations, high noble metal crowns, etc.

Since September 1, 2005, MO HealthNet only covers dental services for adults (age 21 and over) (except individuals under a category of assistance for pregnant women or the blind or nursing facility residents) if the dental care is related to trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury or for the treatment of a medical condition without which the health of the individual would be adversely affected. Treatment for a medical condition requires a written referral from the participant's physician stating that the absence of dental treatment would adversely affect a stated pre-existing medical condition. Dental services for children ages 20 and under and individuals under a category of assistance for pregnant women, the blind or nursing facility residents remain unchanged.

Covered services under the dental program include, but are not limited to, the following: examinations; prophylaxis; fluoride treatments; extractions; anesthesia; crowns; injections; oral surgery; periodontal treatment (in limited cases); pulp treatment; restoration; root canal therapy and x-rays. Orthodontic services, the field of dentistry associated with the correction of abnormally positioned or misaligned teeth, are available only to those eligible's age 20 and under for the most severe malocclusions. Dentures (full or partial), denture adjustments or repairs, and denture duplication or relines are covered only for participants under a category of assistance for pregnant women, the blind, nursing facility residents or children 20 and under.

Senate Bill 577 (94th General Assembly) allowed for coverage of medically necessary dental services for adults if funds were appropriated; however no funding has been appropriated for these services.

A copayment, a portion of the providers' charges paid by the participant, is required on many dental services. Participants under age 19, hospice participants, participants who reside in nursing facilities, residential care facilities, psychiatric hospitals or adult boarding homes, and participants age 18-21 in foster care are exempt from copayments. The copayment, in accordance with title 42 Code of Federal Regulations part 447.54, is based on the lesser of the provider's usual charge for the service or the Maximum Allowable Amount. The copayment is \$.50 for charges of \$10.00 or less, \$1.00 for \$10.01 to \$25.00, \$2.00 for \$25.01 to \$50.00 and \$3.00 for charges of \$50.01 or more. Reimbursement for services to individuals not subject to the copayment is determined by adding together the maximum allowable amount plus one-half the participant cost share amount listed for the procedure. This formula represents the minimum amount allowed for the procedure code. Reimbursement is made at the lower of the providers billed amount or the maximum allowed less any third-party liability (TPL) amounts.

**2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State Statute: RSMo. 208.152, 208.166; Federal law: Social Security Act Section 1905(a)(10); Federal regulation: 42 CFR 440.100

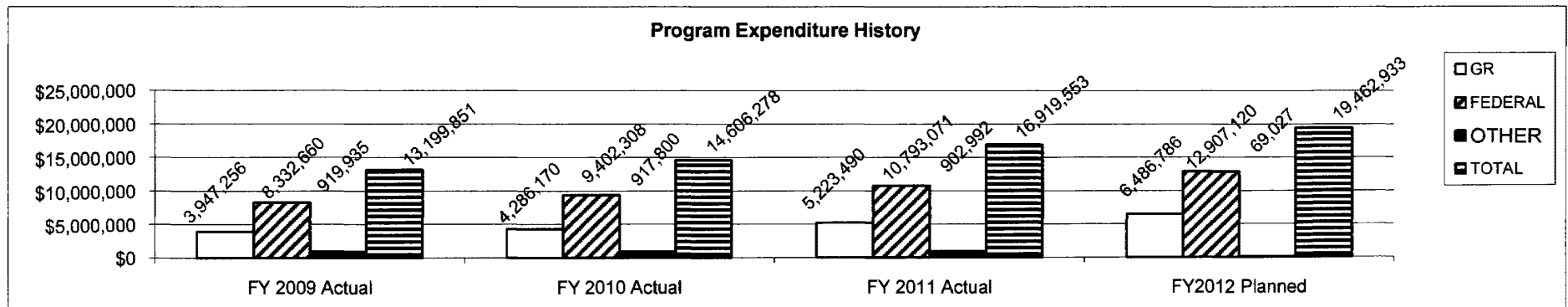
**3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 is a blended 63.41% federal match. The state matching requirement is 36.59%.

**4. Is this a federally mandated program? If yes, please explain.**

Yes for children. No for adults.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



Reverted: \$2,135 Other Funds  
Reserve: \$848,773 Other Funds

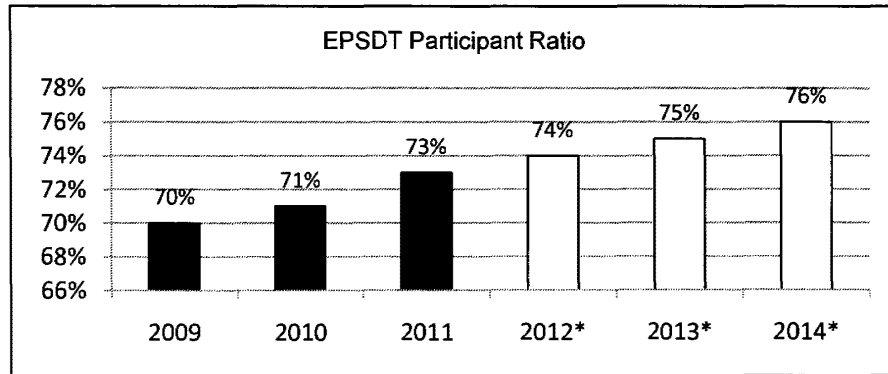
**6. What are the sources of the "Other " funds?**

Health Initiatives Fund (0275) and Healthy Families Trust Fund (0625).

**7a. Provide an effectiveness measure.**

The purpose of the Early Periodic Screening Diagnosis and Treatment/ Healthy Children and Youth (EPSDT/HCY) program is to ensure a comprehensive, preventive health care program for Missouri. The HCY program provides early and periodic medical, dental, vision, and hearing screening, diagnosis and treatment to ameliorate defects and chronic conditions found during the screening. A dental screening is available to children from birth until they become 21 years of age.

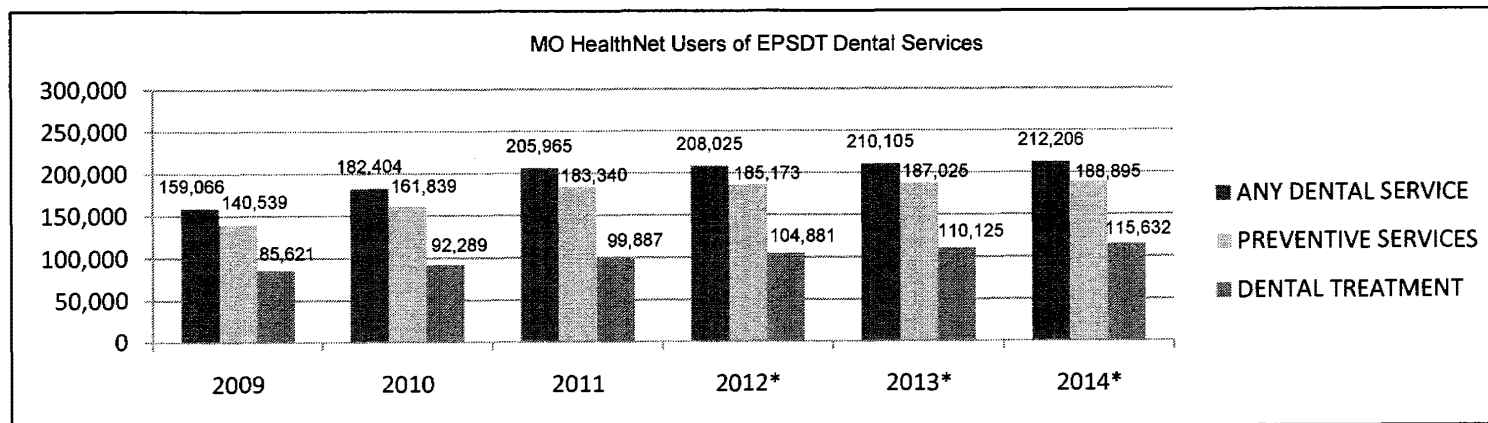
Effectiveness Measure: Increase the EPSDT participant ratio.



\*Data for years 2012 - 2014 is projected.

Note: Based on federal fiscal year reported to CMS - percentage for prior federal fiscal year.

Effectiveness Measure 2: Increase the number of MO HealthNet users of EPSDT preventive dental services.

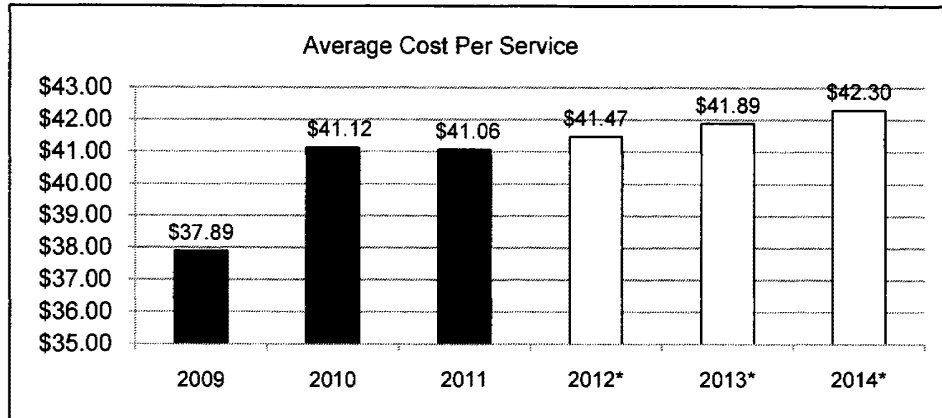


\*Data for years 2012 - 2014 is projected.

Note: Data includes both fee-for-service and Managed Care.

**7b. Provide an efficiency measure.**

Efficiency Measure: Provide adequate dental services to MO HealthNet recipients with the funds appropriated.



\*Data for years 2012 - 2014 is projected.

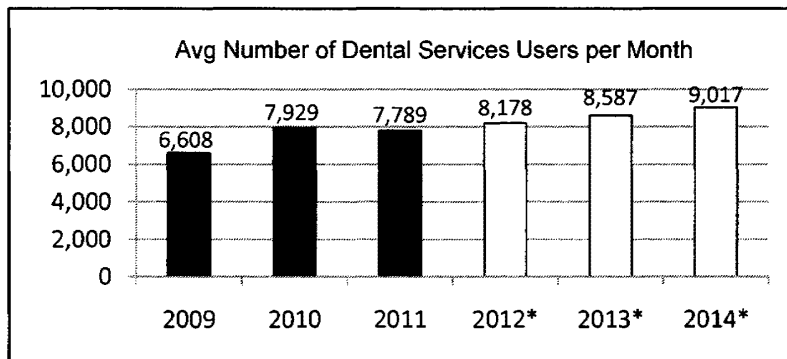
**7c. Provide the number of clients/individuals served, if applicable.**

Participants:

Dental services are available to all MO HealthNet participants\*. In the regions of the state where managed care has been implemented, children have dental services available through the managed care health plans.

Effective September 1, 2005 dental services were available only to children, pregnant women, the blind, and nursing facility residents. Dental services were available to other adults if the dental care was related to trauma or a disease/medical condition. Qualified Medicare Beneficiaries (QMB) were not eligible for dental services.

Senate Bill 577 (94th General Assembly) provided medically necessary dental services for adults; however no appropriations were allocated for these services.



\*Data for years 2012 - 2014 is projected.

**7d. Provide a customer satisfaction measure, if available.**



# **Premium Payments**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>PREMIUM PAYMENTS</b>								
<b>CORE</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	66,245,420	0.00	73,327,895	0.00	73,327,895	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	116,548,324	0.00	133,146,476	0.00	133,146,476	0.00	0	0.00
TOTAL - PD	182,793,744	0.00	206,474,371	0.00	206,474,371	0.00	0	0.00
<b>TOTAL</b>	<b>182,793,744</b>	<b>0.00</b>	<b>206,474,371</b>	<b>0.00</b>	<b>206,474,371</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Caseload Growth - 1886006</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	670,393	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	1,130,770	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	1,801,163	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>1,801,163</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Premium Increase - 1886010</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	3,586,563	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	6,356,619	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	9,943,182	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>9,943,182</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$182,793,744</b>	<b>0.00</b>	<b>\$206,474,371</b>	<b>0.00</b>	<b>\$218,218,716</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Premium Payments

Budget Unit: 90547C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	73,327,895	133,146,476		206,474,371
TRF				
Total	73,327,895	133,146,476		206,474,371
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

## 2. CORE DESCRIPTION

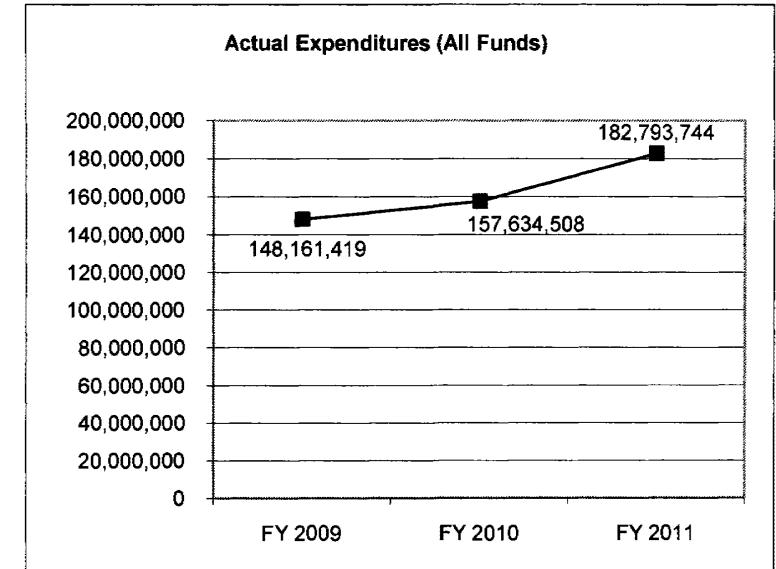
This core request is for the ongoing funding for premium payments for health insurance through the following MO HealthNet programs: Medicare Buy-In and the Health Insurance Premium Payment (HIPPP) program.

## 3. PROGRAM LISTING (list programs included in this core funding)

Premium Payments Program:  
Medicare Part A and Part B Buy-In  
Health Insurance Premium Payment (HIPPP) Program

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	148,162,552	157,634,508	190,403,958	206,474,371
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	148,162,552	157,634,508	190,403,958	N/A
Actual Expenditures (All Funds)	148,161,419	157,634,508	182,793,744	N/A
Unexpended (All Funds)	1,133	0	7,610,214	N/A
Unexpended, by Fund:				
General Revenue	417	0	1,369,622	N/A
Federal	716	0	6,240,592	N/A
Other	0	0	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

(1) Expenditures of \$3,578,354 were paid from the Supplemental Pool.

(2) Expenditures of \$7,214,660 were paid from the Supplemental Pool and \$3,017,827 from HB21 ARRA funding.

(3) Expenditures of \$5,043,211 were paid from HB 16 ARRA funding.

#### 4. FINANCIAL HISTORY

Cost Per Eligible - Per Member Per Month (PMPM)					
	Premium Payments PMPM*	Acute Care PMPM	Total PMPM	Premium Payments Percentage of Acute	Premium Payments Percentage of Total
PTD	\$47.42	\$953.39	\$1,579.47	4.97%	3.00%
Seniors	\$95.06	\$332.63	\$1,293.02	28.58%	7.35%
Custodial Parents	\$0.13	\$403.27	\$416.87	0.03%	0.03%
Children**	\$0.00	\$232.18	\$251.39	0.00%	0.00%
Pregnant Women	\$0.00	\$507.64	\$515.09	0.00%	0.00%

\* Claims only from FY 11 Table 23 Medical Statistics.  
 \*\* CHIP eligibles not included

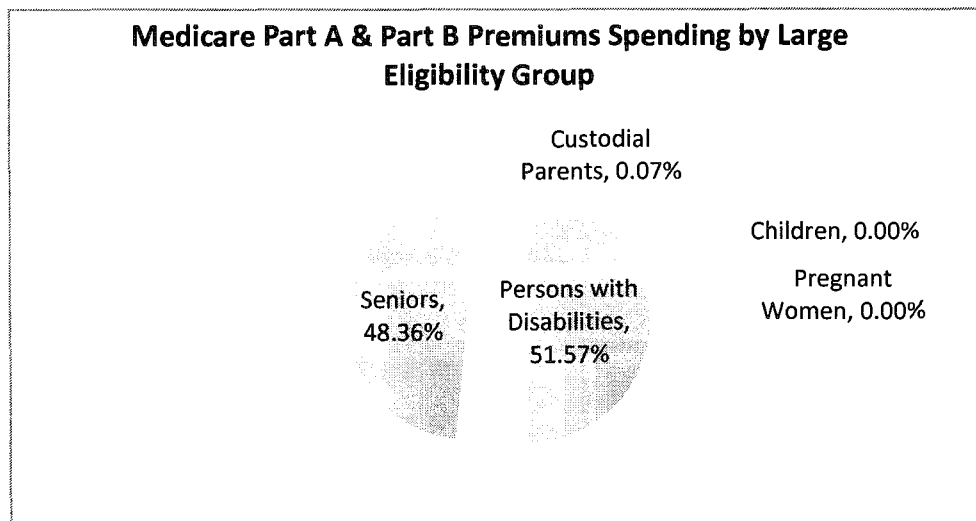
The Cost per Eligible - Per Member Per Month (PMPM) table provides the total PMPM for each large eligibility group. Health care entities use per member per month calculations as a benchmark to monitor, assess, and manage health care costs. The PMPM metric provides MHD management with a high level aggregate spending metric.

PMPM is calculated by dividing costs by the number of eligibles enrolled. Since caseload growth is accounted for when determining PMPM, the PMPM provides management with a better tool than just comparing overall increases in spending.

PMPM by eligibility group and type of service serves as a baseline for management to determine if cost control interventions are working as intended. Monitoring PMPM amounts allow tracking by a population so that a shift in services is reflected in one metric.

The PMPM table reflects the PMPM amounts for premium payments, acute care, and total. The acute care PMPM is made up of payments for the following services: inpatient, physician/lab/x-ray, outpatient/clinic, drugs, managed care payments, Medicare co-pay/deductibles and other acute services administered by MHD. It does **not** include nursing facilities, in-home services, mental health services and state institutions. By comparing the premium payments PMPM to the acute care PMPM, MHD management can monitor the progress of interventions controlled by MHD management.

The Spending by Large Eligibility Group (left) shows the percentage of spending by each eligibility group for the Premium Payments core. It provides a snapshot of what eligibility groups participate, as well as the populations impacted by program changes.



Source: Table 23 Medical Statistics for Fiscal Year 2011

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES****PREMIUM PAYMENTS**

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**5. CORE RECONCILIATION DETAIL**

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	Budget Class	FTE	GR	Federal	Other	Total	Explanation
<b>TAFP AFTER VETOES</b>							
	PD	0.00	73,327,895	133,146,476	0	206,474,371	
	<b>Total</b>	<b>0.00</b>	<b>73,327,895</b>	<b>133,146,476</b>	<b>0</b>	<b>206,474,371</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	73,327,895	133,146,476	0	206,474,371	
	<b>Total</b>	<b>0.00</b>	<b>73,327,895</b>	<b>133,146,476</b>	<b>0</b>	<b>206,474,371</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	73,327,895	133,146,476	0	206,474,371	
	<b>Total</b>	<b>0.00</b>	<b>73,327,895</b>	<b>133,146,476</b>	<b>0</b>	<b>206,474,371</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>PREMIUM PAYMENTS</b>								
<b>CORE</b>								
PROGRAM DISTRIBUTIONS	182,793,744	0.00	206,474,371	0.00	206,474,371	0.00	0	0.00
TOTAL - PD	182,793,744	0.00	206,474,371	0.00	206,474,371	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$182,793,744</b>	<b>0.00</b>	<b>\$206,474,371</b>	<b>0.00</b>	<b>\$206,474,371</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$66,245,420	0.00	\$73,327,895	0.00	\$73,327,895	0.00		0.00
FEDERAL FUNDS	\$116,548,324	0.00	\$133,146,476	0.00	\$133,146,476	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Premium Payments**

**Program is found in the following core budget(s): Premium Payments**

### 1. What does this program do?

*PROGRAM SYNOPSIS: This program pays for health insurance premiums for eligible participants. Payments include premiums for Medicare Part A, Medicare Part B and group health insurance premiums provided under the Health Insurance Premium Payment (HIPP) program. Payment of these premiums transfers medical costs from MO HealthNet to Medicare and other payers.*

#### Medicare Buy-In

The Medicare Buy-in Program allows states to enroll certain groups of eligible individuals in the Medicare Part A and Part B program and pay their premiums. The purpose of buy-in is to permit the state, as part of its total assistance plan, to provide Medicare protection to certain groups of eligible individuals. It transfers medical costs from the Title XIX Medicaid program to the Medicare program - Title XVIII. This process allows the state to realize cost savings through substitution of Medicare liability for the majority of the medical costs before Medicaid reimburses for the services. There are two types of buy-in agreements - "1634 agreements" and "209b". States with "1634 agreements" have the same Medicaid eligibility standards as the Supplemental Security Income (SSI) program. States with more restrictive eligibility standards for Medicaid are "209b" states. The "209b" states make their own buy-in determinations. Missouri is a "209b" state.

The buy-in for Part A began in FY 90 (September 1989). The Part B buy-in has been a MO HealthNet service since January 1968.

#### Health Insurance Premium Payment

The Health Insurance Premium Payment (HIPP) program is a program that pays for the cost of health insurance premiums, coinsurance, and deductibles. The program pays for health insurance for MO HealthNet eligible's when it is "cost effective". "Cost effective" means that it costs less to buy health insurance to cover medical care than to pay for the same services with MO HealthNet funds. Cost effectiveness is determined by comparing the cost of the medical coverage (includes premium payments, coinsurance, and deductibles) with the average cost of each MO HealthNet eligible person in the household. The average cost of each MO HealthNet participant is based on the previous year's MO HealthNet expenditures with like demographic data: age; sex; geographic location (county); type of assistance (MO HealthNet for Families - MAF, Old Age Assistance - OAA, and disabled); and the types of services covered by the group insurance. The HIPP program has been a MO HealthNet program since September 1992.

Provisions of Omnibus Budget Reconciliation Act of 1990 (OBRA 90) require states to purchase group health insurance (such as an employer sponsored insurance) for a MO HealthNet participant (who is eligible to enroll for the coverage) when it is more cost-effective to buy health insurance to cover medical care than to pay for an equivalent set of services with MO HealthNet funds.



**2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State statute: RSMo 208.153; Federal law: Social Security Act Section 1905(p)(1), 1902(a)(10) and 1906; Federal Regulation: 42 CFR 406.26 and 431.625

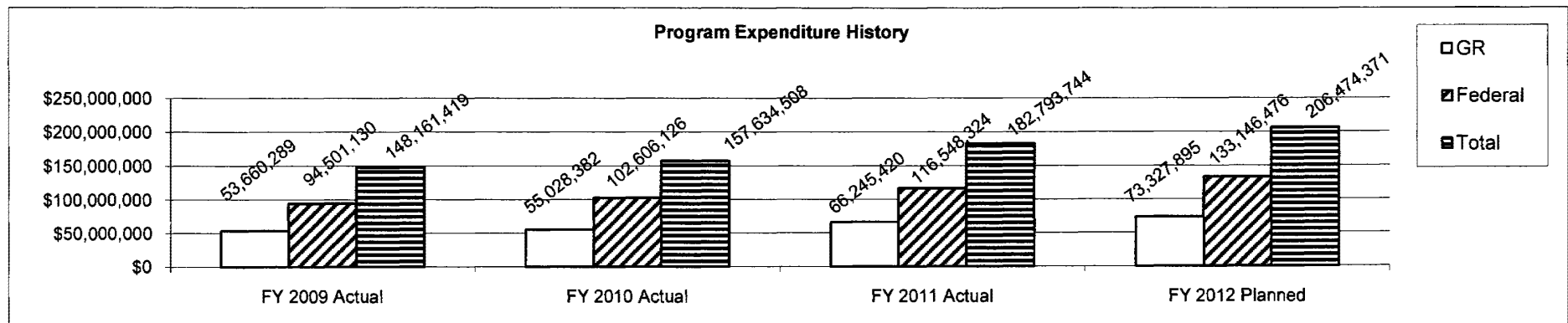
**3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the annual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 is a blended 63.41% federal match. The state matching requirement is 36.59%.

**4. Is this a federally mandated program? If yes, please explain.**

Yes, if the state elects to have a Medicaid program.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**

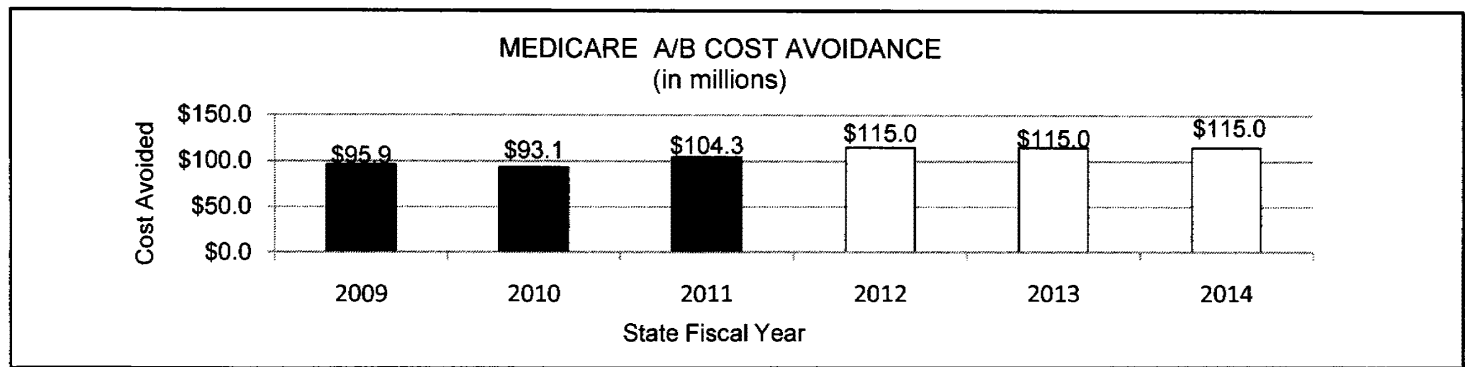


**6. What are the sources of the "Other " funds?**

N/A

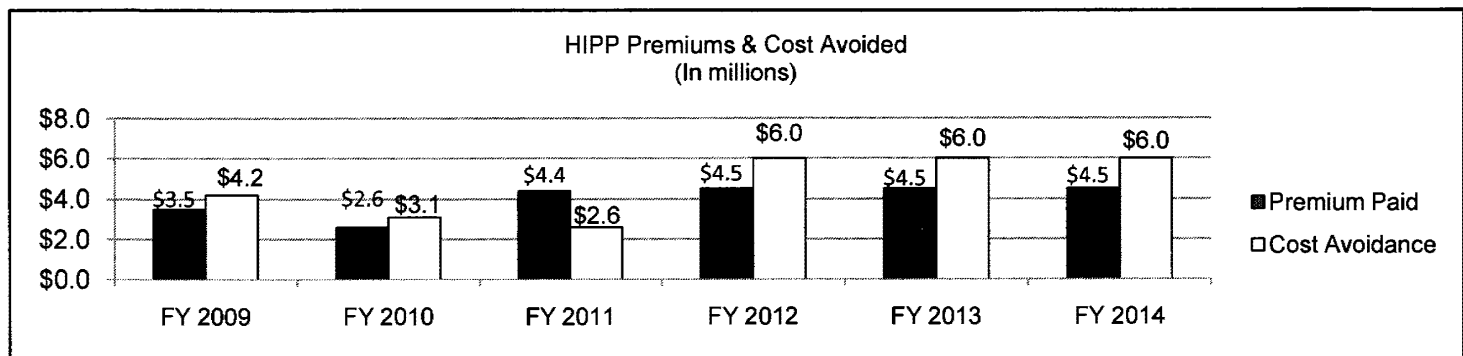
**7a. Provide an effectiveness measure.**

Effectiveness Measure: Increase cost avoidance by paying Medicare premiums for dual eligibles. By paying Medicare premiums for dual eligibles, the MO HealthNet avoided over \$104.3 million in SFY 2011 as shown in the chart below.

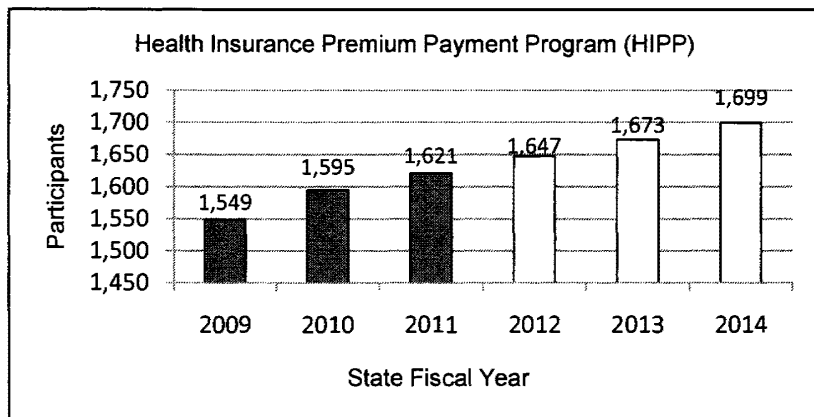
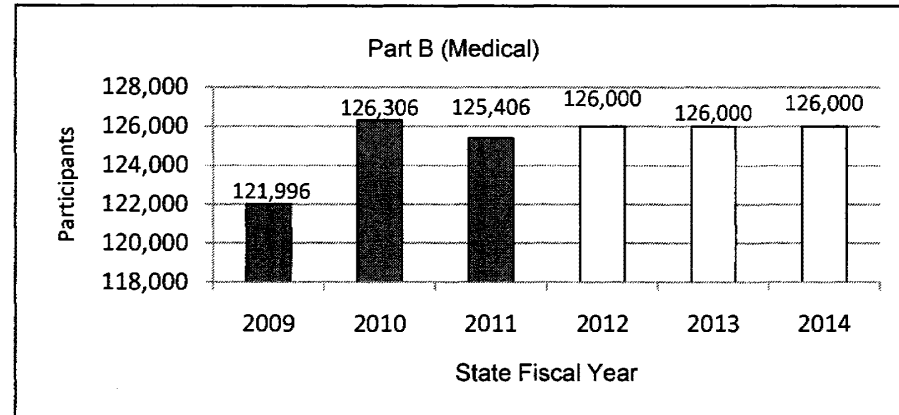
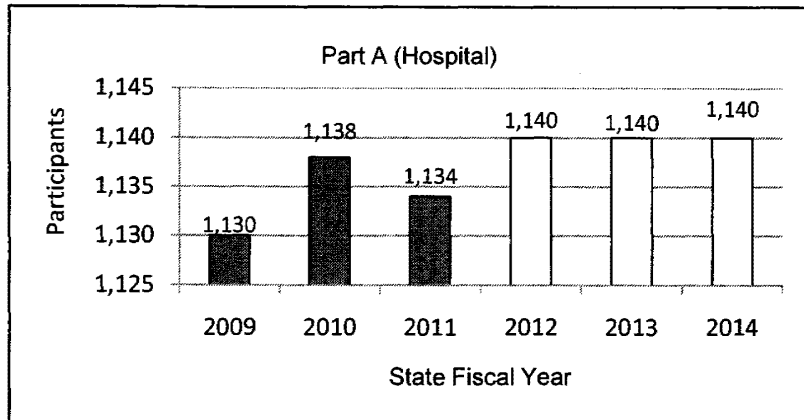


**7b. Provide an efficiency measure.**

Efficiency Measure: Increase cost avoidance by paying for health insurance premiums, coinsurance, and deductibles for Mo HealthNet eligibles when it is cost effective to do so. In FY11, the MO HealthNet Division paid \$4.35 million for health insurance premiums, coinsurance and deductibles and avoided \$2.6 million in costs.



**7c. Provide the number of clients/individuals served, if applicable.**



Participants:

Part A (Hospital) premium payments can be made for: Qualified Medicare Beneficiaries (QMBs) and Qualified Disabled Working Individuals.

Part B (Medical) premium payments can be made for: Individuals meeting certain income standards, QMBs, and Specified Low-Income Medicare Beneficiaries.

HIPP: Provisions of OBRA 90 require states to purchase group health insurance for a MO HealthNet participant when it is more cost effective to buy health insurance to cover medical care than to pay for an equivalent set of services with MO HealthNet funds.

**7d. Provide a customer satisfaction measure, if available.**

**NEW DECISION ITEM  
RANK: 11**

Department: Social Services  
Division: MO HealthNet  
DI Name: Medicare Premium Increases

Budget Unit: 90547C  
DI#: 1886010

**1. AMOUNT OF REQUEST**

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	3,586,563	6,356,619		9,943,182
TRF				
Total	<u>3,586,563</u>	<u>6,356,619</u>		<u>9,943,182</u>
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
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*Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.*

Other Funds:

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
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*Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.*

Other Funds:

**2. THIS REQUEST CAN BE CATEGORIZED AS:**

<input checked="" type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input checked="" type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input type="checkbox"/> Other:	

**3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.**

*NDI SYNOPSIS: Funding is requested for anticipated Medicare Part A and Part B increases.*

Federal law mandates that the Medicare Part A and Part B premiums cover a certain percentage of the cost of the Medicare program. Medicare Part A and Part B premiums are adjusted each January. In FY13, Part A premiums are estimated to be \$468 which consists of FY12 projected of \$459 plus a \$9.00 increase. In FY13, Part B premiums are estimated to be \$128.40 (FY12 projection of \$121.40 plus a projected \$7.00 increase for FY 13).

The Federal Authority is Social Security Act Section 1905(p)(1), 1902(a)(10), and 1906 and Federal Regulations 42 CFR 406.26 and 431.625. The State Authority is RSMo 208.153.

**4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)**

This request is for six months of funding for the calendar year 2012 premium increases and six months of funding for the expected premium increases for calendar year 2013.

Projected participants are based on historical data. The projected premium increases are based on the average increases in premiums for the last few years as well as other information sources. The federal matching rate used is 63.45% for three months and 62.55% for nine months. States are only required to pay the federal share for QIs (Qualified Individual). A QI is an individual with income between 120% and 135% of the federal poverty level with assets of \$6,000 per individual and \$9,000 per couple indexed each year according to Consumer Price Index.

Department Request:	Part A	Part B	QI
Eligibles per month (FY13)	1,216	121,783	4,010
Premium Increase (1/12)	\$9.00	\$6.00	\$6.00
Premium Increase (1/13)	\$9.00	\$7.00	\$7.00

Calendar Year 2012 Increase:

Average eligibles per month	1,216	121,783	4,010
Premium increase for 2012	\$9.00	\$6.00	\$6.00
Number of months to increase	6	6	6
Projected increase 7/12 - 12/12	65,664	4,384,188	144,360

Calendar Year 2013 Increase:

Average eligibles per month	1,216	121,783	4,010
Premium increase for 2013	\$9.00	\$7.00	\$7.00
Number of months to increase	6	6	6
Projected increase 1/13 - 6/13.	65,664	5,114,886	168,420

Total	\$131,328	\$9,499,074	\$312,780
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	Total	GR	Federal
Part A Request	131,328	48,891	82,437
Part B Request	9,499,074	3,537,672	5,961,402
Part B QI	312,780		312,780 QI Federal only
Total	\$9,943,182	\$3,586,563	\$6,356,619

**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

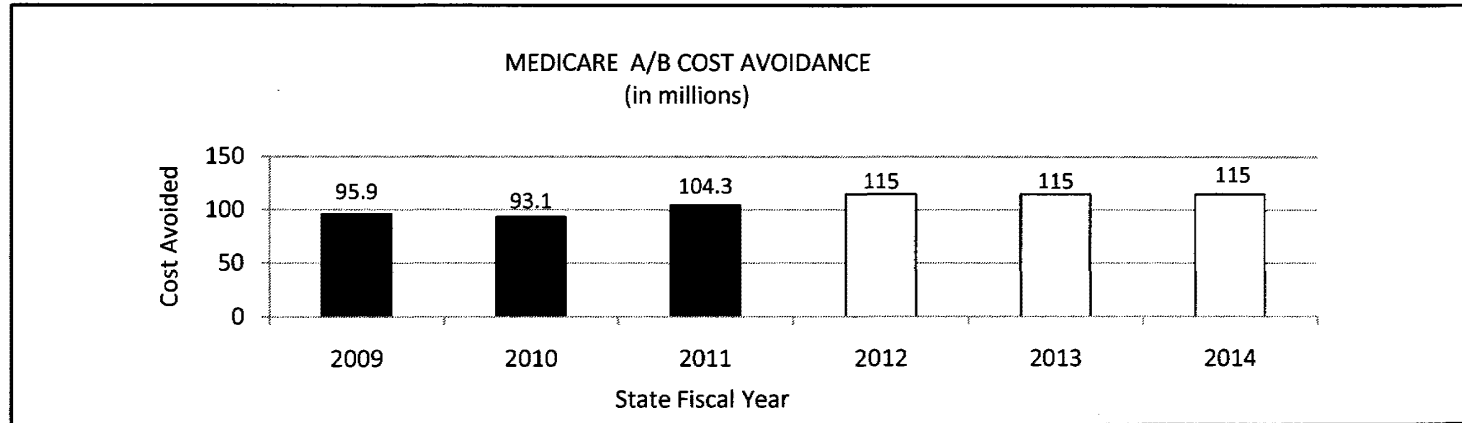
Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	3,586,563		6,356,619		0		9,943,182		
Total PSD	3,586,563		6,356,619		0		9,943,182		0
Transfers							0		
Total TRF	0		0		0		0		0
Grand Total	3,586,563	0.0	6,356,619	0.0	0	0.0	9,943,182	0.0	0

Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions							0		
Total PSD	0		0		0		0		0
Transfers							0		
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

**6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)**

**6a. Provide an effectiveness measure.**

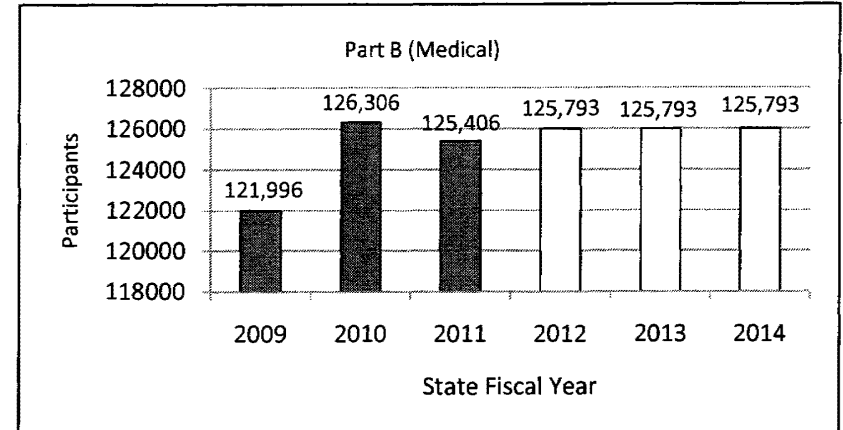
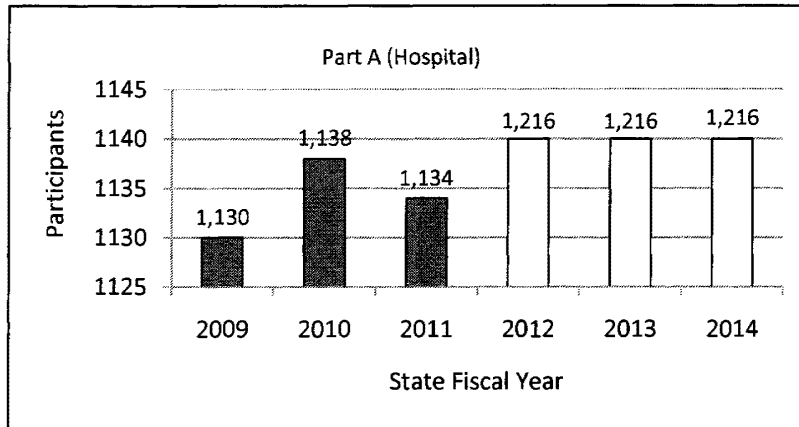
Effectiveness Measure: Increase cost avoidance by paying Medicare premiums for dual eligible's. By paying Medicare premiums for dual eligible's, the MO HealthNet avoided over \$104.3 million in SFY 2011 as shown in the chart below.



**6b. Provide an efficiency measure.**

Efficiency Measure: Increase cost avoidance by paying for health insurance premiums, coinsurance, and deductibles for Mo HealthNet eligible's when it is cost effective to do so. In FY11, the MO HealthNet Division paid \$4.35 million for health insurance premiums, coinsurance and deductibles and avoided \$2.6 million in costs.

6c. Provide the number of clients/individuals served, if applicable.



Participants: Part A (Hospital) premium payments can be made for: Qualified Medicare Beneficiaries (QMBs) and Qualified Disabled Working Individuals. Part B (Medical) premium payments can be made for: Individuals meeting certain income standards, QMBs, and Specified Low-Income Medicare Beneficiaries. HIPP: Provisions of OBRA 90 require states to purchase group health insurance for a MO HealthNet participant when it is more cost effective to buy health insurance to cover medical care than to pay for an equivalent set of services with MO HealthNet funds.

6d. Provide a customer satisfaction measure, if available.

**7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:**



# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>PREMIUM PAYMENTS</b>								
Premium Increase - 1886010								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	9,943,182	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	9,943,182	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$0</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	<b>\$9,943,182</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$3,586,563	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$6,356,619	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

# **Nursing Facilities**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN	
<b>NURSING FACILITIES</b>									
<b>CORE</b>									
PROGRAM-SPECIFIC									
GENERAL REVENUE	132,069,132	0.00	133,598,846	0.00	133,598,846	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	355,799,123	0.00	354,607,642	0.00	354,607,642	0.00	0	0.00	
UNCOMPENSATED CARE FUND	58,516,478	0.00	58,516,478	0.00	58,516,478	0.00	0	0.00	
THIRD PARTY LIABILITY COLLECT	2,478,014	0.00	2,592,981	0.00	2,592,981	0.00	0	0.00	
NURSING FACILITY FED REIM ALLW	9,105,106	0.00	9,134,756	0.00	9,134,756	0.00	0	0.00	
HEALTHY FAMILIES TRUST	17,973	0.00	17,973	0.00	17,973	0.00	0	0.00	
TOTAL - PD	557,985,826	0.00	558,468,676	0.00	558,468,676	0.00	0	0.00	
<b>TOTAL</b>	<b>557,985,826</b>	<b>0.00</b>	<b>558,468,676</b>	<b>0.00</b>	<b>558,468,676</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	
<b>GRAND TOTAL</b>	<b>\$557,985,826</b>	<b>0.00</b>	<b>\$558,468,676</b>	<b>0.00</b>	<b>\$558,468,676</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	

# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Nursing Facilities

Budget Unit: 90549C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	133,598,846	354,607,642	70,262,188	558,468,676
TRF				
Total	<b>133,598,846</b>	<b>354,607,642</b>	<b>70,262,188</b>	<b>558,468,676</b>

FTE 0.00

<b>Est. Fringe</b>	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				

FTE

<b>Est. Fringe</b>	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Uncompensated Care Fund (UCF) (0108)  
Healthy Families Trust Fund (HFTF) (0625)  
Third Party Liability Collections Fund (TPL) (0120)  
Nursing Facility Federal Reimbursement Allowance (NFFRA) (0196)

## 2. CORE DESCRIPTION

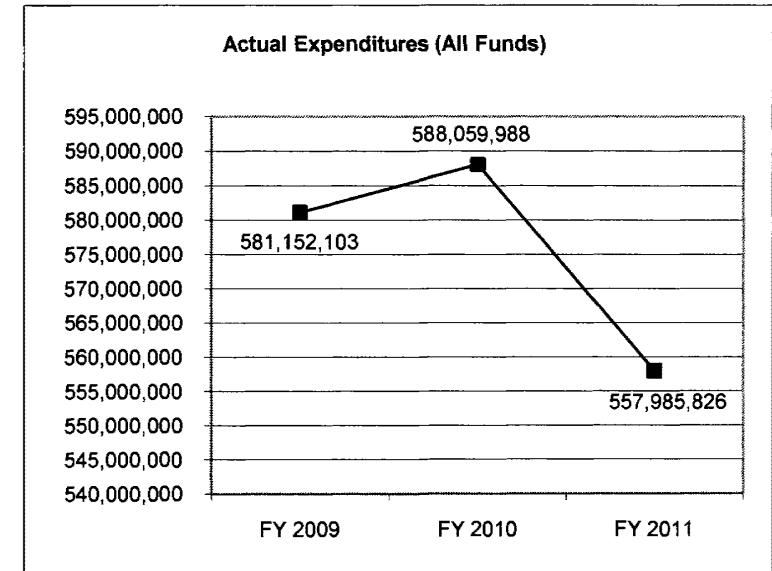
This core is for ongoing funding for payments for long-term nursing care for MO HealthNet participants.

## 3. PROGRAM LISTING (list programs included in this core funding)

Nursing Facilities

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	607,082,123	624,721,523	584,400,260	558,468,676
Less Reverted (All Funds)	(5,277,944)	(5,375,638)	0	N/A
Budget Authority (All Funds)	601,804,179	619,345,885	584,400,260	N/A
Actual Expenditures (All Funds)	581,152,103	588,059,988	557,985,826	N/A
Unexpended (All Funds)	20,652,076	31,285,897	26,414,434	N/A
Unexpended, by Fund:				
General Revenue	3,093,353	803,309	11,984,863	N/A
Federal	16,437,360	29,502,098	14,284,954	N/A
Other	1,121,363	980,490	144,617	N/A
	(1)	(2) (3)	(4)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

(1) Agency reserve of \$4,121,362: \$3,000,000 General Revenue and \$1,121,362 in Third Party Liability Collections fund.

(2) Agency reserve of \$7,166,946 in Federal funds.

(3) Expenditures of \$8,000,000 paid from Nursing Facility FRA.

(4) Expenditures went down due to repricing of Medicare/Medicaid crossover claims for Medicare Part A and Part C coinsurance. The coinsurance reimbursement was limited to the fee-for-service amount that would have been paid by MHD for those same service dates.

#### 4. FINANCIAL HISTORY

Cost Per Eligible - Per Member Per Month (PMPM)					
	Nursing Facility PMPM*	Acute Care PMPM	Total PMPM	Nursing Facility Percentage of Acute	Nursing Facility Percentage of Total
PTD	\$123.77	\$953.39	\$1,579.47	12.98%	7.84%
Seniors	\$687.59	\$332.63	\$1,293.02	206.71%	53.18%
Custodial Parents	\$0.09	\$403.27	\$416.87	0.02%	0.02%
Children**	\$0.01	\$232.18	\$251.39	0.00%	0.00%
Pregnant Women	\$0.00	\$507.64	\$515.09	0.00%	0.00%

\* Claims only from FY 11 Table 23 Medical Statistics. Add-on payments funded from FRA provider tax not included.

\*\* CHIP eligibles not included

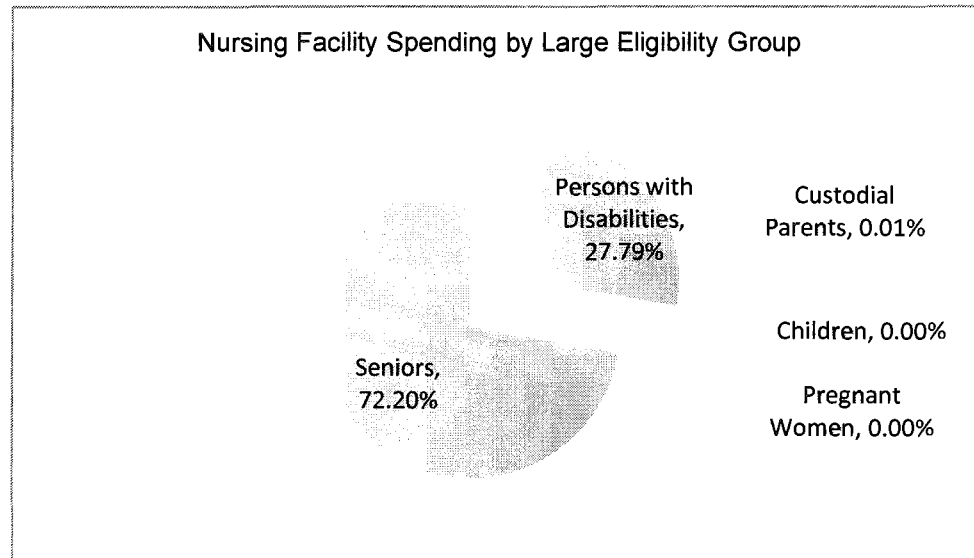
The Cost per Eligible - Per Member Per Month (PMPM) table provides the total PMPM for each large eligibility group. Health care entities use per member per month calculations as a benchmark to monitor, assess, and manage health care costs. The PMPM metric provides MHD management with a high level aggregate spending metric.

PMPM is calculated by dividing costs by the number of eligibles enrolled. Since caseload growth is accounted for when determining PMPM, the PMPM provides management with a better tool than just comparing overall increases in spending.

PMPM by eligibility group and type of service serves as a baseline for management to determine if cost control interventions are working as intended. Monitoring PMPM amounts allow tracking by a population so that a shift in services is reflected in one metric.

The PMPM table reflects the PMPM amounts for nursing facilities, acute care, and total. The acute care PMPM is made up of payments for the following services: inpatient, physician/lab/x-ray, outpatient/clinic, drugs, managed care payments, Medicare co-pay/deductibles and other acute services administered by MHD. It does **not** include nursing facilities, in-home services, mental health services and state institutions. By comparing the nursing facility PMPM to the acute care PMPM, MHD management can monitor the progress of interventions controlled by MHD management.

The Spending by Large Eligibility Group (left) shows the percentage of spending by each eligibility group for nursing facilities. It provides a snapshot of what eligibility groups are receiving nursing facility services as well as the populations impacted by program changes.



Source: Table 23 Medical Statistics for Fiscal Year 2011

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES****NURSING FACILITIES**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	133,598,846	354,607,642	70,262,188	558,468,676	
	<b>Total</b>	<b>0.00</b>	<b>133,598,846</b>	<b>354,607,642</b>	<b>70,262,188</b>	<b>558,468,676</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	133,598,846	354,607,642	70,262,188	558,468,676	
	<b>Total</b>	<b>0.00</b>	<b>133,598,846</b>	<b>354,607,642</b>	<b>70,262,188</b>	<b>558,468,676</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	133,598,846	354,607,642	70,262,188	558,468,676	
	<b>Total</b>	<b>0.00</b>	<b>133,598,846</b>	<b>354,607,642</b>	<b>70,262,188</b>	<b>558,468,676</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>NURSING FACILITIES</b>								
<b>CORE</b>								
PROGRAM DISTRIBUTIONS	557,985,826	0.00	558,468,676	0.00	558,468,676	0.00	0	0.00
TOTAL - PD	557,985,826	0.00	558,468,676	0.00	558,468,676	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$557,985,826</b>	<b>0.00</b>	<b>\$558,468,676</b>	<b>0.00</b>	<b>\$558,468,676</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$132,069,132	0.00	\$133,598,846	0.00	\$133,598,846	0.00		0.00
FEDERAL FUNDS	\$355,799,123	0.00	\$354,607,642	0.00	\$354,607,642	0.00		0.00
OTHER FUNDS	\$70,117,571	0.00	\$70,262,188	0.00	\$70,262,188	0.00		0.00



## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Nursing Facilities**

**Program is found in the following core budget(s): Nursing Facilities**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides payment for long-term nursing care for MO HealthNet participants.*

This program provides long-term institutional care for MO HealthNet participants. An average of 505 nursing homes were enrolled in the MO HealthNet program in SFY 11 with an average of 22,688 participants per month. Nursing facility care users are 2.41% of the total MO HealthNet participants. However, the nursing facility program comprises almost 13.61% of the total program dollars.

Payment is based on a per diem rate established for each nursing home by the Institutional Reimbursement Unit (IRU) of the MO HealthNet Division. A portion of the per diem rate is paid from the Nursing Facilities budget section and a portion from the Nursing Facilities Federal Reimbursement Allowance (NFFRA) section.

The current reimbursement methodology is based on a cost component system. The components are patient care, ancillary, administration and capital. A working capital allowance, incentives and the NFFRA are also elements of the total reimbursement rate. Patient care includes medical supplies, nursing, supplies, activities, social services and dietary costs. Ancillary services are therapies, barber and beauty shop, laundry and housekeeping. Administration includes plant operation costs and administrative costs. Capital costs are reimbursed through a fair rental value methodology. The capital component includes rental value, return, computed interest, borrowing costs and pass-through expenses. Property insurance and real estate and personal property taxes (the pass-through expenses) are the only part of the capital component that is trended. The working capital allowance per diem rate is equal to 1.1 months of the total of the facility's per diem rates for the patient care, ancillary and administration cost components multiplied by the prime rate plus 2%. There are three incentives which are paid to qualified facilities to encourage patient care expenditures and cost efficiencies in administration. The patient care incentive is 10% of a facility's patient care per diem up to a maximum of 130% of the patient care median. The ancillary incentive is paid to all facilities whose costs are below the ancillary ceiling. The amount is one-half of the difference between certain parameters. The multiple component incentive is allowed for facilities whose patient care and ancillary per diem rate are between 60 - 80% of total per diem rate. An additional amount is allowed for facilities with high MO HealthNet utilization. The current NFFRA is also included in the total reimbursement rate since it is an allowable MO HealthNet cost.

The reimbursement system is a prospective system. When the rate is established on a particular cost report year, it will not change until the rates are rebased on another cost report year. This rate may be adjusted for global per diem rate adjustments, such as trends, which are granted to the industry as a whole and are applied to the previously established rate.

Providers are reimbursed for MO HealthNet participants based on the residents' days of care multiplied by the facility's Title XIX per diem rate less any patient surplus amount. The amount of money the MO HealthNet participant contributes to his or her nursing home care is called patient surplus. The patient surplus is based upon the participant's income and expenses. The amount of the patient surplus is calculated by a Family Support Division caseworker. The gross income (usually a Social Security benefit check) of the participant is adjusted for the personal needs allowance, an allotment of money allocated for use by the community spouse or dependent children and medical deductions (Medicare premiums or private medical insurance premiums that the participant pays for his own medical coverage). The remainder is the patient surplus. The participant and the nursing facility are notified of the amount of the patient surplus by the Family Support Division. The nursing home provider is responsible for obtaining the patient surplus from the participant.

During SFY 10, MHD implemented a change in reimbursement of Medicare/Medicaid crossover claims for Medicare Part A and Medicare Advantage/Part C inpatient skilled nursing facility benefits. Effective for dates of service beginning April 1, 2010, MHD no longer automatically reimburses the coinsurance or cost sharing amount determined by Medicare or the Medicare Advantage Plan for inpatient nursing facility services. MHD now determines the MO HealthNet reimbursement for the coinsurance or cost sharing amount of crossover claims which is limited to the fee-for-service amount that would be paid by MHD for those services.

Beginning January 1, 2010 (HB 395) the personal needs allowance must be increased by an amount equal to the product of the percentage of the Social Security benefit cost-of-living adjustment and the average amount that MO HealthNet participants are required to contribute to their cost of care, not to exceed \$5.00 in any year. When the allowance reaches \$50, there will be no further increases unless authorized by annual appropriation. There was not a Social Security cost-of-living adjustment for 2011, therefore the personal needs allowance was not increased, and remains at \$30.

**2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State statute: RSMo. 208.152, 208.153, 208.159; 208.201 Federal law: Social Security Act Section 1905(a)(4); Federal regulations: 42CFR 440.40 and 440.210

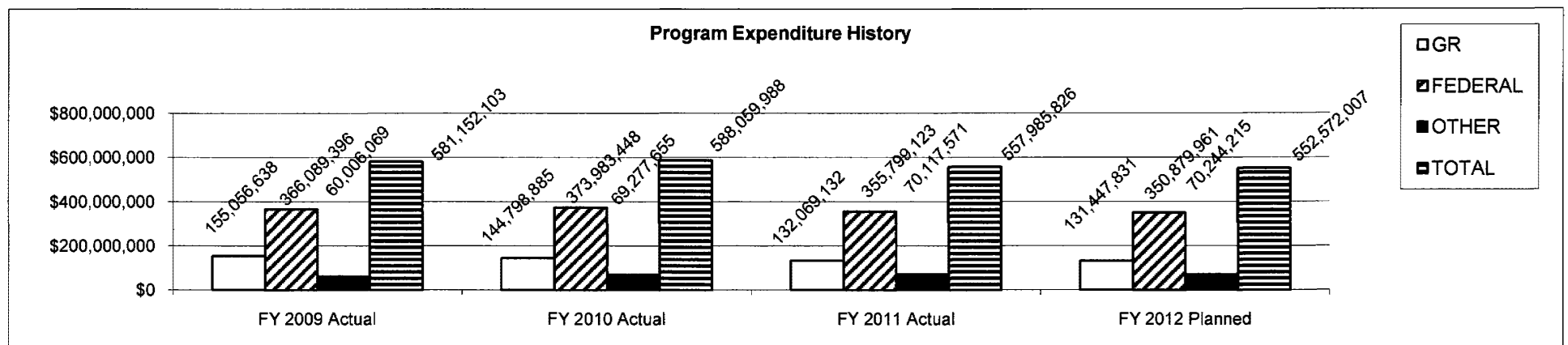
**3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures made in accordance with the approved State Plan. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY 11 is a blended 63.41% federal match. The state matching requirement is 36.59%.

**4. Is this a federally mandated program? If yes, please explain.**

Yes, for people over age 21.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



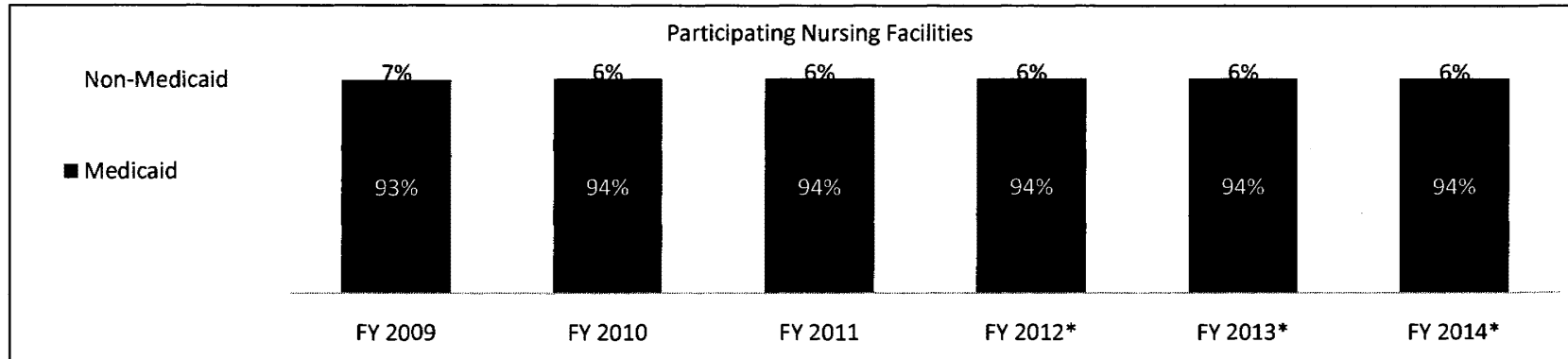
Reserve: \$17,973 Other Funds; \$3,727,681 Federal Funds  
 Reverted: \$2,151,015 General Revenue

## 6. What are the sources of the "Other " funds?

Uncompensated Care Fund (0108), Third Party Liability Collections Fund (0120), Healthy Families Trust Fund (0625) and Nursing Facilities Federal Reimbursement Allowance Fund (0196).

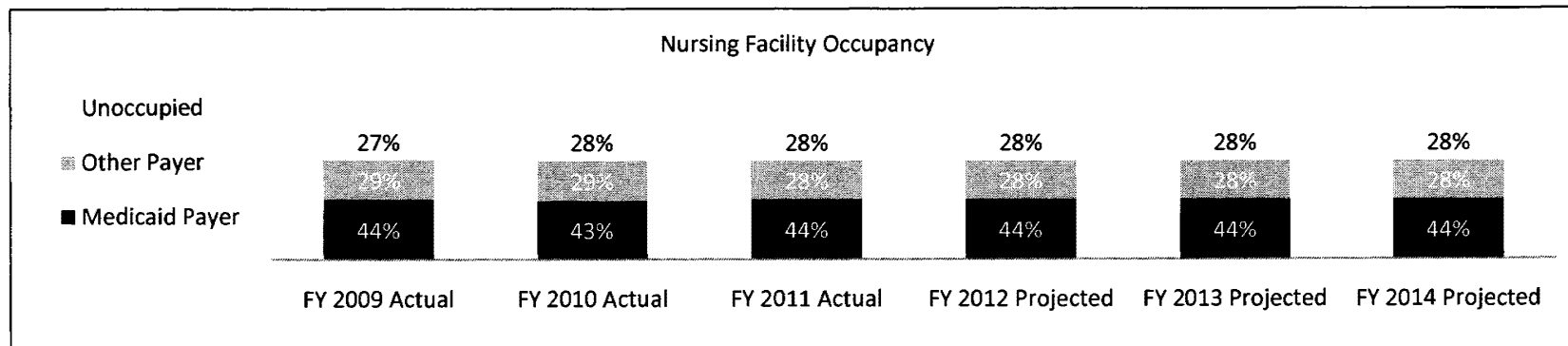
## 7a. Provide an effectiveness measure.

Effectiveness Measure 1: Provide reimbursement that is sufficient to ensure nursing facilities enroll in the MO HealthNet program. During the past three state fiscal years, over 90% of licensed nursing facilities in the state participated in the MO HealthNet program.



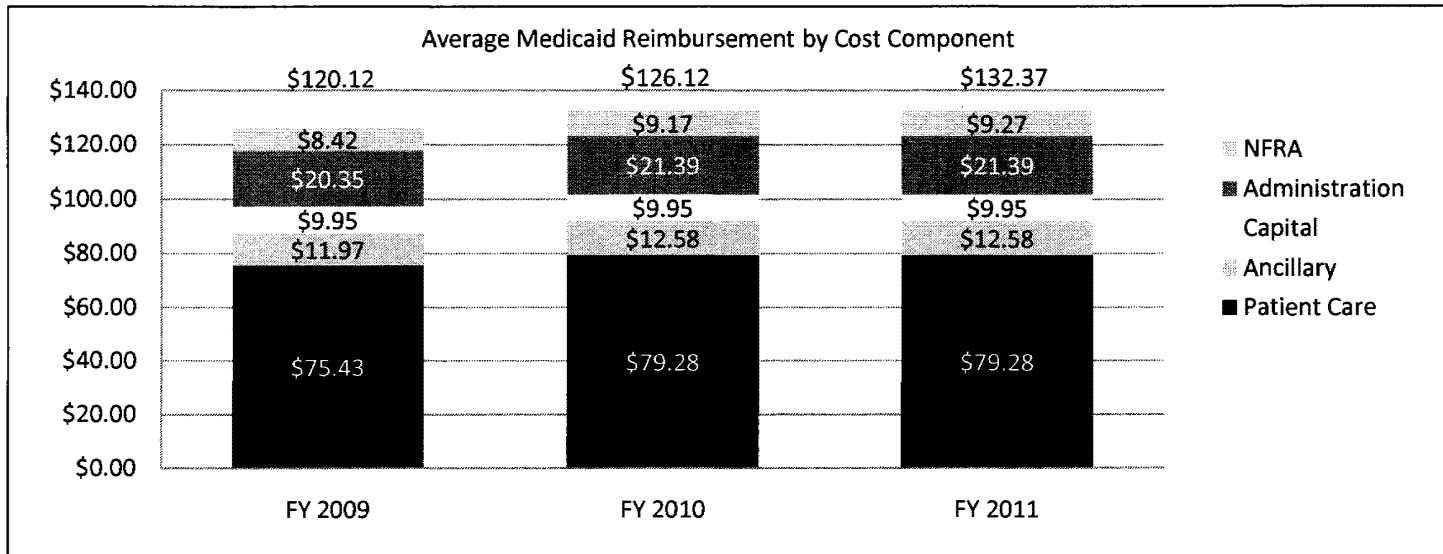
\* FY 2012-FY 2014 data is projected.

Effectiveness Measure 2: Provide adequate reimbursement to ensure MO HealthNet participants have sufficient access to care. In the past three state fiscal years, at least 26% of nursing facility beds were unoccupied. There are a sufficient number of beds available to care for MO HealthNet participants.



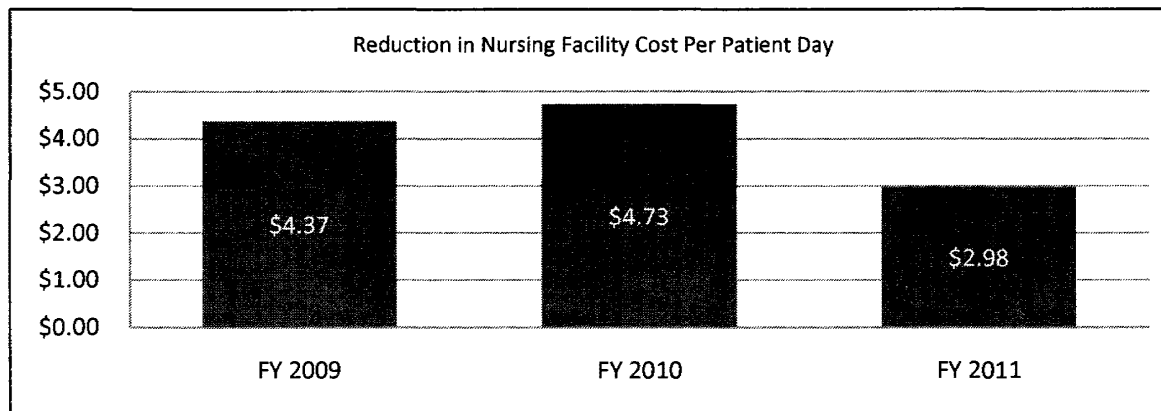
**7b. Provide an efficiency measure.**

Efficiency Measure 1: Target and encourage quality patient care through the nursing facility reimbursement methodology. In the past three state fiscal years, more than 50% of the average Medicaid reimbursement rate related to patient care.



The NFRA amount in the chart for SFY 10 of \$9.17 is an average for the entire SFY, actual rates were \$9.07 & \$9.27.

Efficiency Measure 2: Ensure nursing facility costs included in determining MO HealthNet reimbursement are allowable by performing audits of the provider's cost reports. During the past three state fiscal years, over \$4.00 of nursing facility costs per patient day were disallowed as a result of MHD audits.

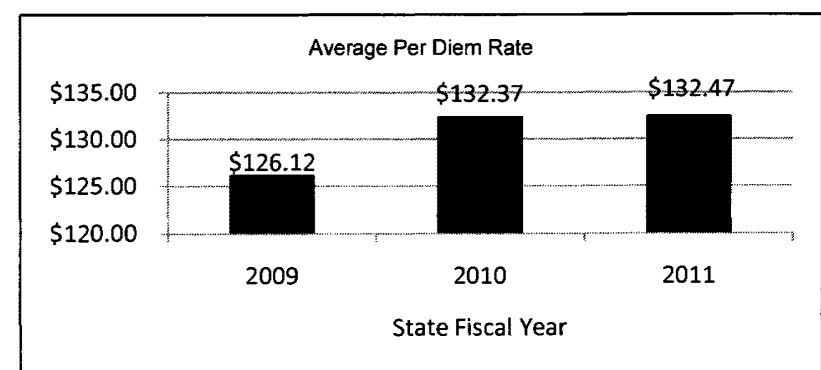
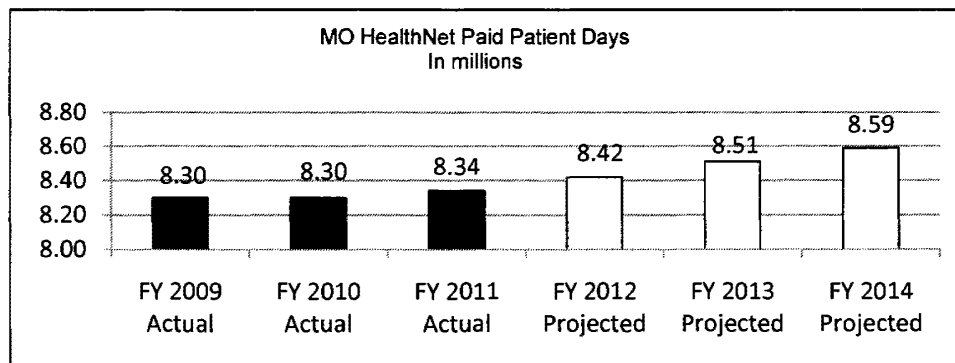
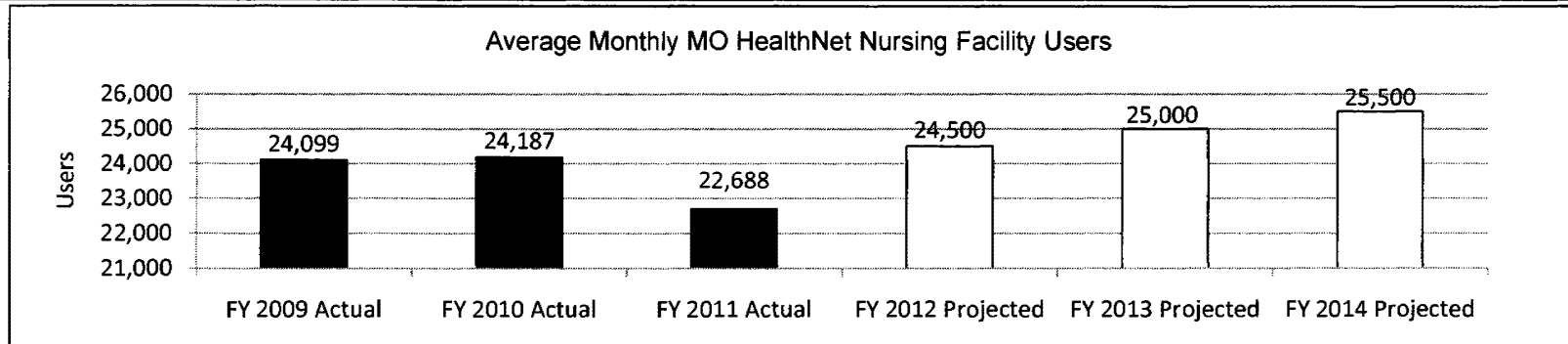


Efficiency Measure 3: Target and encourage quality patient care by utilizing a reimbursement methodology that allows for higher reimbursement of patient care costs while limiting administration and capital costs. The ceilings for the cost components related to patient care (patient care and ancillary) are 120% of the median. Various limitations are applied to administration and capital costs, some of which are identified below.

Cost Component Ceilings	
Patient Care	120% of median
Ancillary	120% of median
Administration	110% of median

Limitations on Administration & Capital Costs
* Minimum Utilization of 85% applied to Administration and Capital
* Owners' Compensation is limited
* Home office costs are limited to 7% of gross revenues less contractual allowance
* Related party transactions are limited to the cost incurred by the related party
* Fair Rental Value calculation is used to determine the capital cost component which limits excessive real estate costs.

**7c. Provide the number of clients/individuals served, if applicable.**



**7d. Provide a customer satisfaction measure, if available.**

# Home Health

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN	
<b>HOME HEALTH</b>									
<b>CORE</b>									
PROGRAM-SPECIFIC									
GENERAL REVENUE	2,251,638	0.00	2,531,358	0.00	2,531,358	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	4,422,117	0.00	4,678,833	0.00	4,678,833	0.00	0	0.00	
HEALTH INITIATIVES	154,526	0.00	159,305	0.00	159,305	0.00	0	0.00	
TOTAL - PD	6,828,281	0.00	7,369,496	0.00	7,369,496	0.00	0	0.00	
<b>TOTAL</b>	<b>6,828,281</b>	<b>0.00</b>	<b>7,369,496</b>	<b>0.00</b>	<b>7,369,496</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	
<b>Caseload Growth - 1886006</b>									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	44,588	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	75,208	0.00	0	0.00	
TOTAL - PD	0	0.00	0	0.00	119,796	0.00	0	0.00	
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>119,796</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	
<b>GRAND TOTAL</b>	<b>\$6,828,281</b>	<b>0.00</b>	<b>\$7,369,496</b>	<b>0.00</b>	<b>\$7,489,292</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Home Health

Budget Unit: 90564C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	2,531,358	4,678,833	159,305	7,369,496
TRF				
Total	<u>2,531,358</u>	<u>4,678,833</u>	<u>159,305</u>	<u>7,369,496</u>
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Health Initiatives Fund (HIF) (0275)

## 2. CORE DESCRIPTION

This core request is for on-going funding for payments for services provided through the Home Health program. This program is designed to help a MO HealthNet participant remain in their home instead of seeking institutional care.

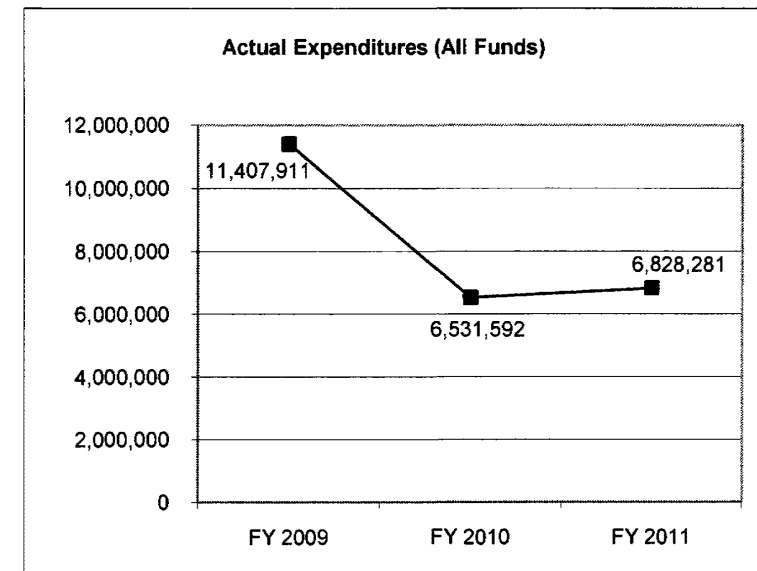
## 3. PROGRAM LISTING (list programs included in this core funding)

Home Health Services



#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	12,337,028	7,126,576	7,083,897	7,369,496
Less Reverted (All Funds)	(330,806)	(268,872)	(4,779)	N/A
Budget Authority (All Funds)	12,006,222	6,857,704	7,079,118	N/A
Actual Expenditures (All Funds)	11,407,911	6,531,592	6,828,281	N/A
Unexpended (All Funds)	598,311	326,112	250,837	N/A
Unexpended, by Fund:				
General Revenue	31,663	0	0	N/A
Federal	566,648	326,112	250,837	N/A
Other	0	0	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

- (1) The Home Health and PACE programs were funded through one appropriation in FY 2009. Beginning in FY 2010 they were divided into separate budgeting units.

Home Health expenditures for FY 09: \$6,173,885

- (2) Expenditures of \$81,493 were paid from the Supplemental Pool.

- (3) Expenditures of \$115,201 were paid from the Supplemental Pool.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES****HOME HEALTH**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	2,531,358	4,678,833	159,305	7,369,496	
	<b>Total</b>	<b>0.00</b>	<b>2,531,358</b>	<b>4,678,833</b>	<b>159,305</b>	<b>7,369,496</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	2,531,358	4,678,833	159,305	7,369,496	
	<b>Total</b>	<b>0.00</b>	<b>2,531,358</b>	<b>4,678,833</b>	<b>159,305</b>	<b>7,369,496</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	2,531,358	4,678,833	159,305	7,369,496	
	<b>Total</b>	<b>0.00</b>	<b>2,531,358</b>	<b>4,678,833</b>	<b>159,305</b>	<b>7,369,496</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
HOME HEALTH								
CORE								
PROGRAM DISTRIBUTIONS	6,828,281	0.00	7,369,496	0.00	7,369,496	0.00	0	0.00
TOTAL - PD	6,828,281	0.00	7,369,496	0.00	7,369,496	0.00	0	0.00
GRAND TOTAL	\$6,828,281	0.00	\$7,369,496	0.00	\$7,369,496	0.00	\$0	0.00
GENERAL REVENUE	\$2,251,638	0.00	\$2,531,358	0.00	\$2,531,358	0.00		0.00
FEDERAL FUNDS	\$4,422,117	0.00	\$4,678,833	0.00	\$4,678,833	0.00		0.00
OTHER FUNDS	\$154,526	0.00	\$159,305	0.00	\$159,305	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Home Health**

**Program is found in the following core budget(s): Home Health**

### **1. What does this program do?**

*PROGRAM SYNOPSIS: This program funds Home Health services. These programs help MO HealthNet participants remain in their homes instead of seeking institutional care.*

Home Health services provide primarily medically oriented treatment or supervision on an intermittent basis to individuals with an acute illness which can be therapeutically managed at home. Prior to October 1, 2010, individuals were required to be homebound to receive Home Health Program services. The homebound requirement was removed effective October 1, 2010. Home Health care follows a written plan of treatment established and reviewed every 62 days by a physician. Services included in the Home Health benefit are skilled nursing, home health aide, physical, occupational and speech therapies, and supplies. Participants who are eligible under aid categories for children, pregnant women, or blind individuals are eligible for physical, occupational and speech therapy provided through Home Health. Therapy must be reasonable and necessary for restoration to an optimal level of functioning following an injury or illness.

Home Health services are reimbursed on a per visit basis. A visit is a personal contact for a period of time not to exceed three hours in a client's home. Payment for the visit is the lower of the provider's actual billed charge or the state MO HealthNet agency established capped amount. The current MO HealthNet cap is \$64.15. Home Health is a mandatory service added to the MO HealthNet program in July 1972. The program serves participants throughout the state.

### **2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State statute: RSMo. 208.152; Federal law: Social Security Act Section 1905(a)(24), 1905(a)(7) and 1915(c);

Federal Regulations: 42 CFR 440.170(f), 440.210, 440.130 and 440.180 and 460. Social Security Act Sections: 1894, 1905(a) and 1934.

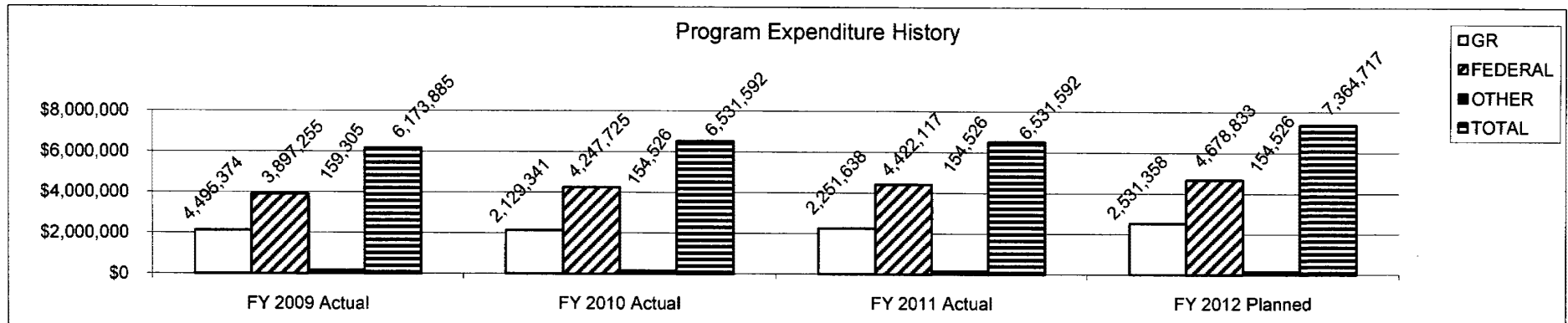
### **3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 was a blended 63.41% federal match. The state matching requirement is 36.59%.

### **4. Is this a federally mandated program? If yes, please explain.**

Home Health is a mandatory Medicaid program.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



Reverted: \$4,779 Other Funds

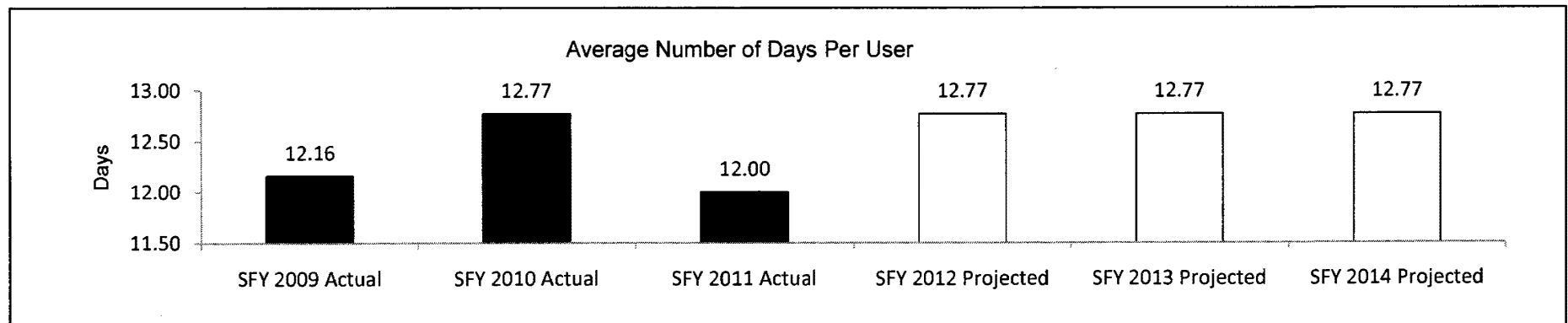
Funding for the Home Health and PACE programs were combined in the same appropriation in FY 09. In FY 10, funding was recommended for both programs in separate appropriations. The Program Expenditure History above provides expenditures for the Home Health program only.

**6. What are the sources of the "Other" funds?**

Health Initiatives Fund (0275).

**7a. Provide an effectiveness measure.**

Effectiveness Measure: Home health plans are reviewed every 62 days. Providing health care at home is less costly than providing care in the hospital.

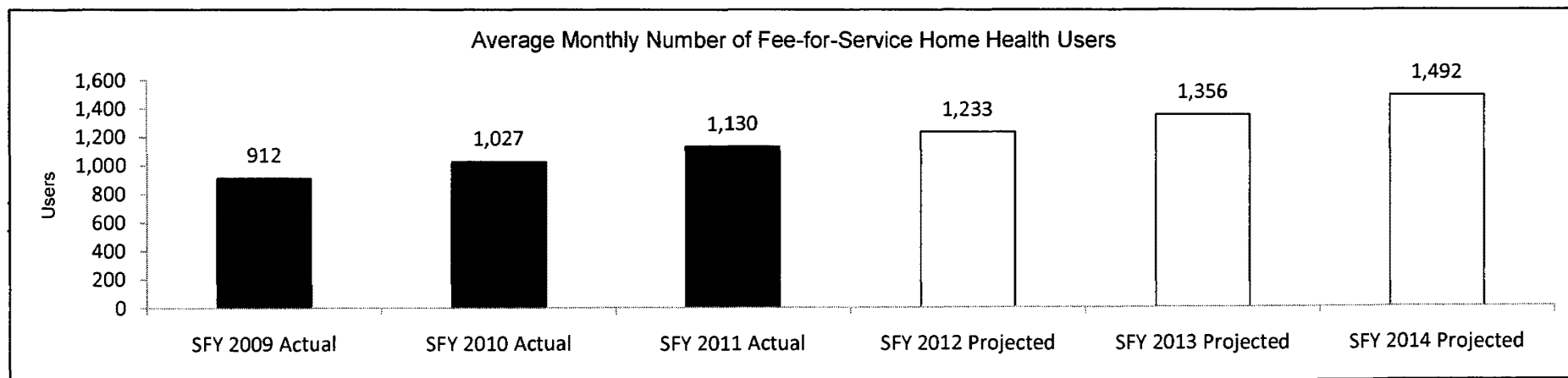


User Count by Number of Days					
SFY	0-60	61-90	91-120	121+	Total
SFY 2009 Actual	17,010	30	10	24	17,074
SFY 2010 Actual	16,722	61	21	12	16,816
SFY 2011 Actual	19,320	45	15	12	19,392
SFY 2012 Projected	22,218	52	17	14	22,301
SFY 2013 Projected	25,551	60	20	16	25,647
SFY 2014 Projected	29,383	68	23	18	29,492

**7b. Provide an efficiency measure.**

**7c. Provide the number of clients/individuals served, if applicable.**

Home Health skilled nurse visits and home health aide services are available to all MO HealthNet fee-for-service (FFS) and Managed Care participants while home health therapy services are limited to children and individuals in a category of assistance for the blind or pregnant.



**7d. Provide a customer satisfaction measure, if available.**

**PACE**

# FY13 Department of Social Services Report #9

# DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PACE								
CORE								
PROGRAM-SPECIFIC								
GENERAL REVENUE	1,464,091	0.00	1,552,734	0.00	1,552,734	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	2,897,537	0.00	3,520,959	0.00	3,520,959	0.00	0	0.00
TOTAL - PD	4,361,628	0.00	5,073,693	0.00	5,073,693	0.00	0	0.00
TOTAL	4,361,628	0.00	5,073,693	0.00	5,073,693	0.00	0	0.00
GRAND TOTAL	\$4,361,628	0.00	\$5,073,693	0.00	\$5,073,693	0.00	\$0	0.00



# CORE DECISION ITEM

Department: Social Services  
 Division: MO HealthNet  
 Core: Programs for All-Inclusive Care for the Elderly (PACE)

Budget Unit: 90568C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	1,552,734	3,520,959		5,073,693
TRF				
Total	1,552,734	3,520,959		5,073,693
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

## 2. CORE DESCRIPTION

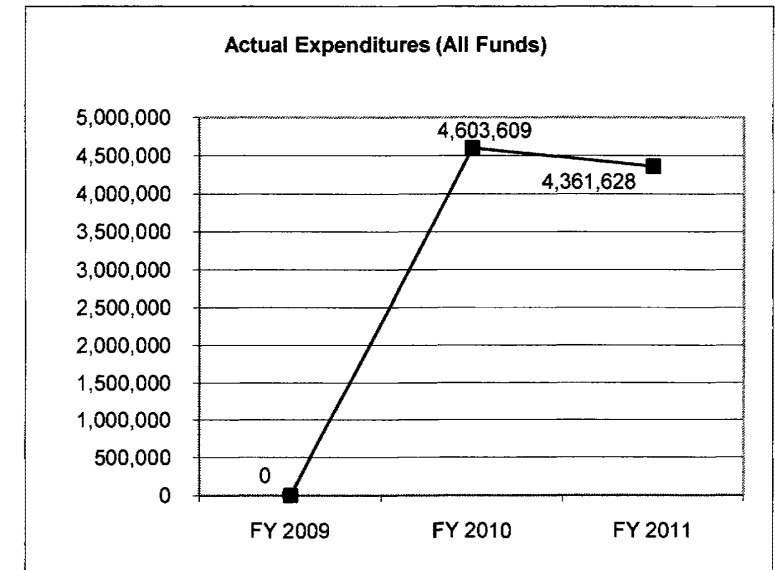
This core request is for on-going funding for payments for services provided through the PACE program. This program is designed to help a MO HealthNet participant remain in their home instead of seeking institutional care.

## 3. PROGRAM LISTING (list programs included in this core funding)

Programs for All-Inclusive Care for the Elderly (PACE)

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	0	6,324,826	4,613,575	5,073,693
Less Reverted (All Funds)	0	(594,677)	0	N/A
Budget Authority (All Funds)	0	5,730,149	4,613,575	N/A
Actual Expenditures (All Funds)	0	4,603,609	4,361,628	N/A
Unexpended (All Funds)	0	1,126,540	251,947	N/A
Unexpended, by Fund:				
General Revenue	0	7,890	0	N/A
Federal	0	1,118,650	251,947	N/A
Other	0	0	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

(1) The Home Health and PACE programs were funded through one appropriation in FY 2009.

PACE expenditures for FY 09: \$5,234,026

(2) The Home Health and PACE programs were divided into separate budgeting units in FY 2010.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES****PACE**

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**5. CORE RECONCILIATION DETAIL**

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	Budget Class	FTE	GR	Federal	Other	Total	Explanation
<hr/>							
<b>TAFP AFTER VETOES</b>							
	PD	0.00	1,552,734	3,520,959	0	5,073,693	
	<b>Total</b>	<b>0.00</b>	<b>1,552,734</b>	<b>3,520,959</b>	<b>0</b>	<b>5,073,693</b>	
<hr/>							
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	1,552,734	3,520,959	0	5,073,693	
	<b>Total</b>	<b>0.00</b>	<b>1,552,734</b>	<b>3,520,959</b>	<b>0</b>	<b>5,073,693</b>	
<hr/>							
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	1,552,734	3,520,959	0	5,073,693	
	<b>Total</b>	<b>0.00</b>	<b>1,552,734</b>	<b>3,520,959</b>	<b>0</b>	<b>5,073,693</b>	
<hr/>							

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PACE								
CORE								
PROGRAM DISTRIBUTIONS	4,361,628	0.00	5,073,693	0.00	5,073,693	0.00	0	0.00
TOTAL - PD	4,361,628	0.00	5,073,693	0.00	5,073,693	0.00	0	0.00
GRAND TOTAL	\$4,361,628	0.00	\$5,073,693	0.00	\$5,073,693	0.00	\$0	0.00
GENERAL REVENUE	\$1,464,091	0.00	\$1,552,734	0.00	\$1,552,734	0.00		0.00
FEDERAL FUNDS	\$2,897,537	0.00	\$3,520,959	0.00	\$3,520,959	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Program of All Inclusive Care for the Elderly (PACE)**

**Program is found in the following core budget(s): PACE**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Funds the Program of All Inclusive Care for the Elderly (PACE). This program helps MO HealthNet participants remain in their homes instead of seeking institutional care.*

The goal is to maximize each participant's potential and continued residence in the home and community by providing preventive primary care and supports to the individual while in the home and community. The PACE program helps the participant stay as independent as possible. The PACE organization is the individual's sole source provider guaranteeing access to services, but not to a specific provider.

The PACE organization provides a full range of preventive, primary, acute, and long-term care services 24 hours per day, 7 days per week. The PACE Center is open Monday through Friday 8 AM to 5 PM to offer services on-site in an adult day health center setting. The PACE organization also provides in-home services as deemed necessary by the PACE Interdisciplinary Team (IDT). All medical services the individual requires while enrolled in the PACE program are the financial responsibility of the PACE provider.

PACE combines adult day settings, home care, interdisciplinary teams, transportation systems, and capitated payment systems so that providers can respond to the unique needs of each frail, elderly individual served.

The Missouri Department of Social Services, MO HealthNet Division, is the state administering agency for the PACE program.

To be eligible to enroll in the PACE program individuals must be at least 55 years old, live in the PACE service area, have been certified by the Missouri Department of Health and Senior Services to have met the nursing home level of care of 21 points or higher, and be recommended by the PACE staff for PACE program services as the best option for their care.

At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety.

Enrollment in the PACE program is always voluntary and participants have the option to return to the fee-for-service system at any time. Eligibility to enroll in the PACE program is not restricted to Medicare beneficiaries or MO HealthNet participants. A potential PACE enrollee may, but is not required to be entitled to Medicare Part A, enrolled under Medicare Part B, or eligible for MO HealthNet.

Attendance at the PACE center is determined by the interdisciplinary team and based on the needs and preferences of the participants. Some participants attend every day and some only 2-3 times per week. The PACE organization provides transportation to and from the PACE center each day the participant is scheduled to attend.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152 and 208.168; Federal Regulations: 42 CFR 460

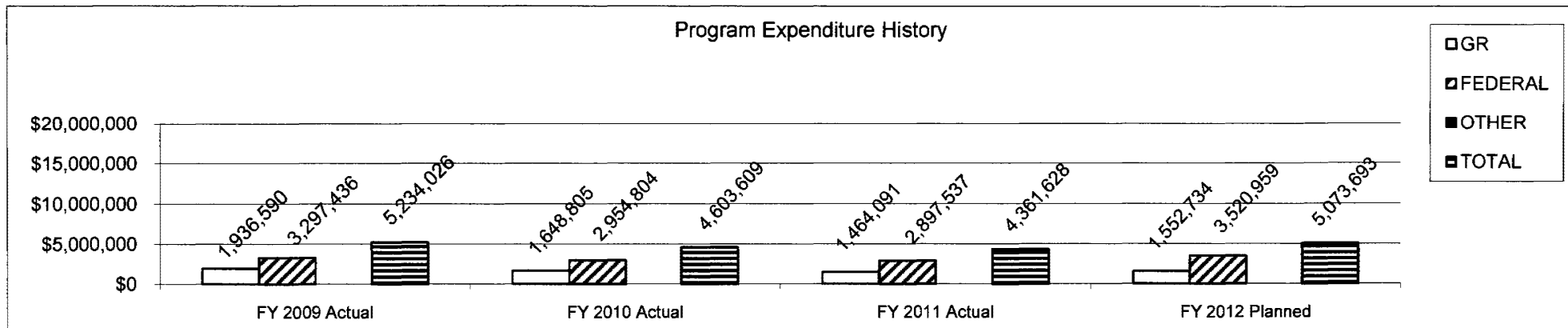
**3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 was a blended 63.41% federal match. The state matching requirement is 36.59%.

**4. Is this a federally mandated program? If yes, please explain.**

PACE is an optional program.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



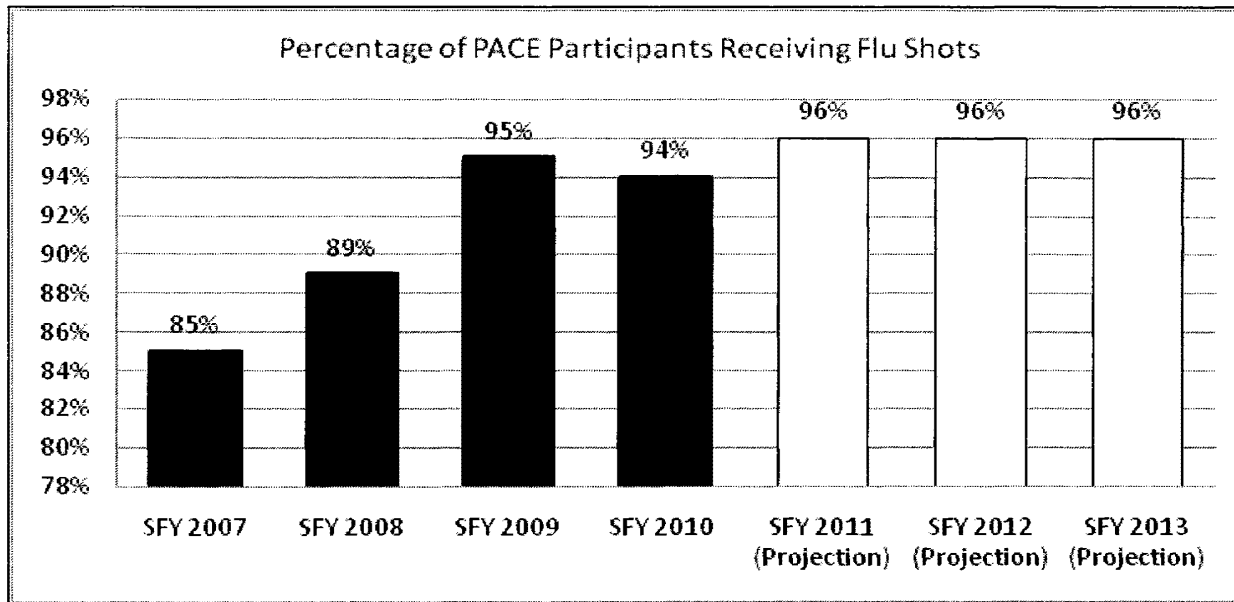
Funding for the Home Health and PACE programs were combined in the same appropriation in FY 09. In FY 10, funding was recommended for both programs in separate appropriations. The Program Expenditure History above provides expenditures for the PACE program only.

**6. What are the sources of the "Other" funds?**

N/A

**7a. Provide an effectiveness measure.**

PACE offers flu shots to all of their participants to protect their participants from the flu and the serious problems it creates for the frail elderly.



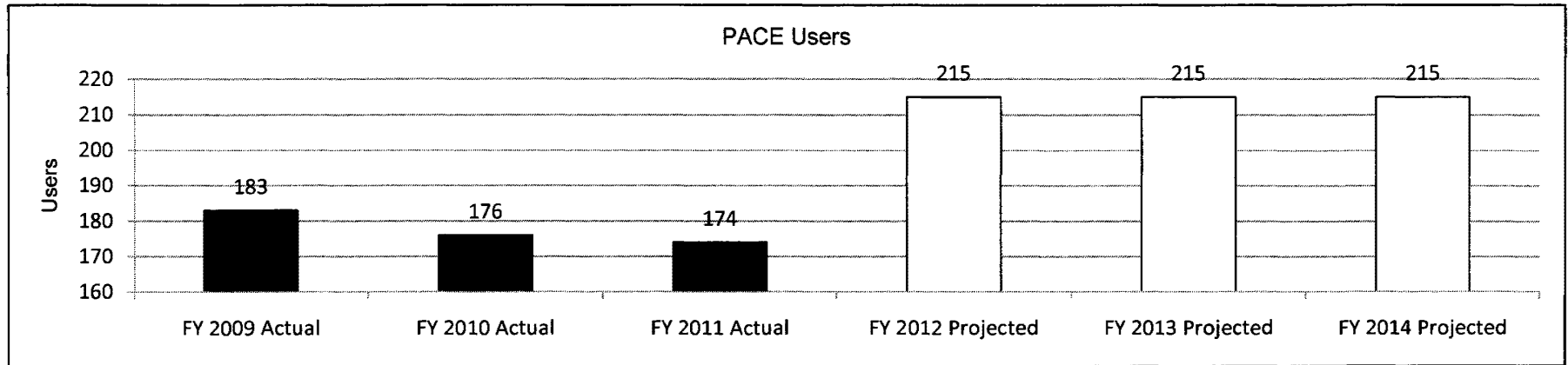
**7b. Provide an efficiency measure.**

The PACE program helps MO HealthNet participants remain in their homes instead of seeking institutional care under the fee-for-service program by helping them stay as independent as possible. While some PACE participants need to move into a Nursing Home, the participants remain enrolled in PACE, and the PACE provider is responsible for all services provided to these participants. A significant portion of PACE participants continue to live at home and receive services under the PACE program.

PACE Participants				
SFY	Users	Reside in NF	Reside In Their Home	% Reside in Home
FY 2009 Actual	183	15	168	92%
FY 2010 Actual	176	26	150	85%
FY 2011 Actual	174	29	145	83%
FY 2012 Projected	215	33	182	85%
FY 2013 Projected	215	33	182	85%
FY 2014 Projected	215	33	182	85%

**7c. Provide the number of clients/individuals served, if applicable.**

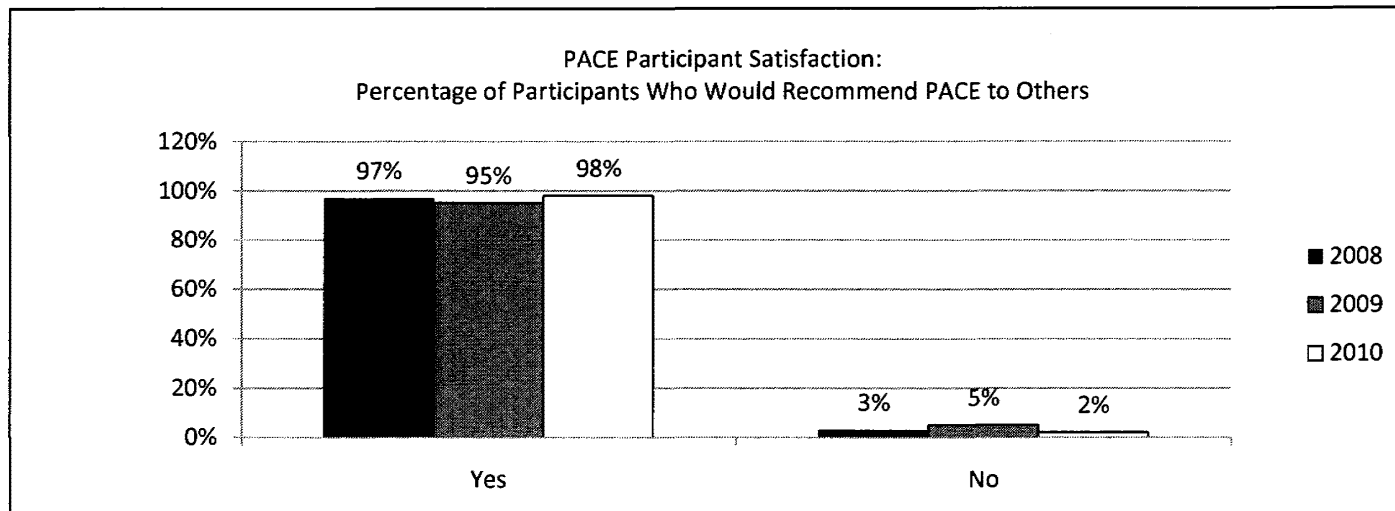
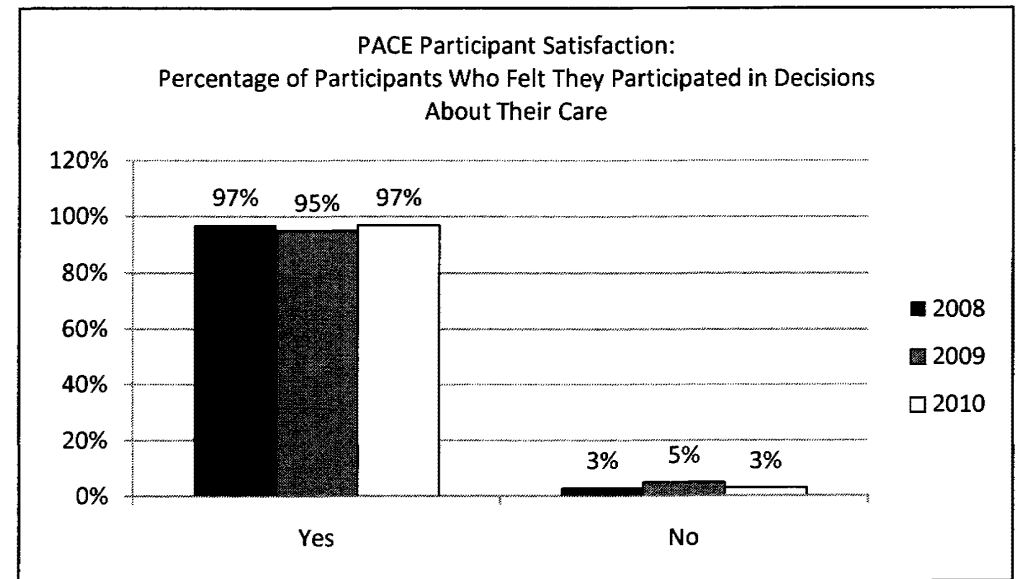
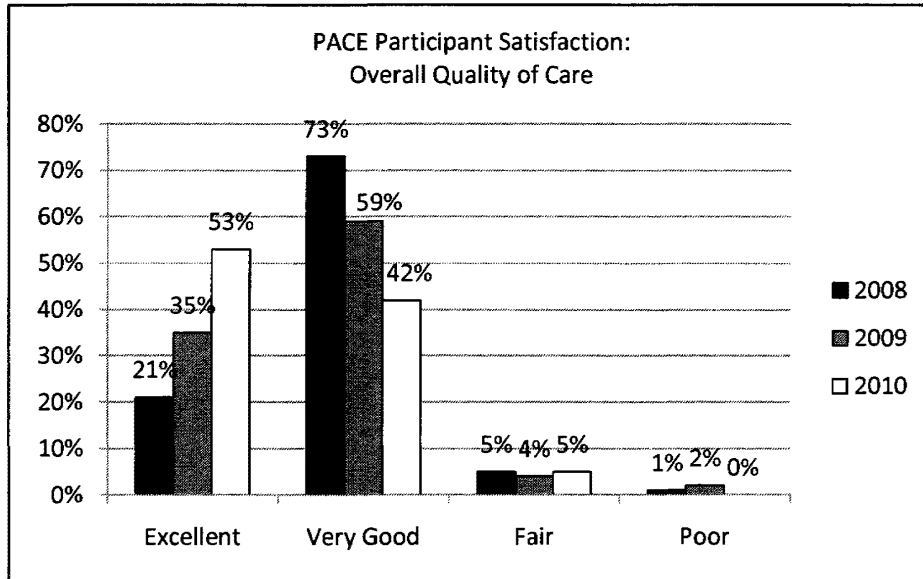
Users include dual participants, MO HealthNet participants and Medicare-only participants.





**7d. Provide a customer satisfaction measure, if available.**

Alexian Brothers Community Services performs annual Participant Satisfaction Surveys.



# **Rehab and Specialty Services**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>REHAB AND SPECIALTY SERVICES</b>								
<b>CORE</b>								
EXPENSE & EQUIPMENT								
GENERAL REVENUE	734,444	0.00	872,000	0.00	872,000	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	709,001	0.00	844,000	0.00	844,000	0.00	0	0.00
TOTAL - EE	1,443,445	0.00	1,716,000	0.00	1,716,000	0.00	0	0.00
PROGRAM-SPECIFIC								
GENERAL REVENUE	78,820,966	0.00	80,775,861	0.00	80,775,861	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	142,581,946	0.00	162,561,313	0.00	162,561,313	0.00	0	0.00
NURSING FACILITY FED REIM ALLW	1,414,043	0.00	1,414,043	0.00	1,414,043	0.00	0	0.00
HEALTH INITIATIVES	189,035	0.00	194,881	0.00	194,881	0.00	0	0.00
HEALTHY FAMILIES TRUST	831,745	0.00	831,745	0.00	831,745	0.00	0	0.00
AMBULANCE SERVICE REIMB ALLOW	0	0.00	10,141,830	0.00	10,141,830	0.00	0	0.00
TOTAL - PD	223,837,735	0.00	255,919,673	0.00	255,919,673	0.00	0	0.00
<b>TOTAL</b>	<b>225,281,180</b>	<b>0.00</b>	<b>257,635,673</b>	<b>0.00</b>	<b>257,635,673</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Caseload Growth - 1886006</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	676,761	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	1,141,512	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	1,818,273	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>1,818,273</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Hospice Rate Increase - 1886011</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	176,688	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	298,003	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	474,691	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>474,691</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$225,281,180</b>	<b>0.00</b>	<b>\$257,635,673</b>	<b>0.00</b>	<b>\$259,928,637</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

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# CORE DECISION ITEM

Department: Social Services  
 Division: MO HealthNet  
 Core: Rehab and Specialty Services

Budget Unit: 90550C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request					FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total		GR	Federal	Other	Total
PS					PS				
EE	872,000	844,000		1,716,000	EE				
PSD	80,775,861	162,561,313	12,582,499	255,919,673	PSD				
TRF					TRF				
Total	81,647,861	163,405,313	12,582,499	257,635,673	Total				
FTE				0.00	FTE				

<b>Est. Fringe</b>	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

<b>Est. Fringe</b>	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds: Healthy Families Trust Fund (0625)  
 Health Initiatives Fund (HIF) (0275)  
 Nursing Facility Federal Reimbursement Allowance (NFFRA) (0196)  
 Ambulance Service Reimbursement Allowance (0958)

Other Funds:

Note: An "E" is requested for the \$10,141,830 Ambulance Service Reimbursement Allowance.

## 2. CORE DESCRIPTION

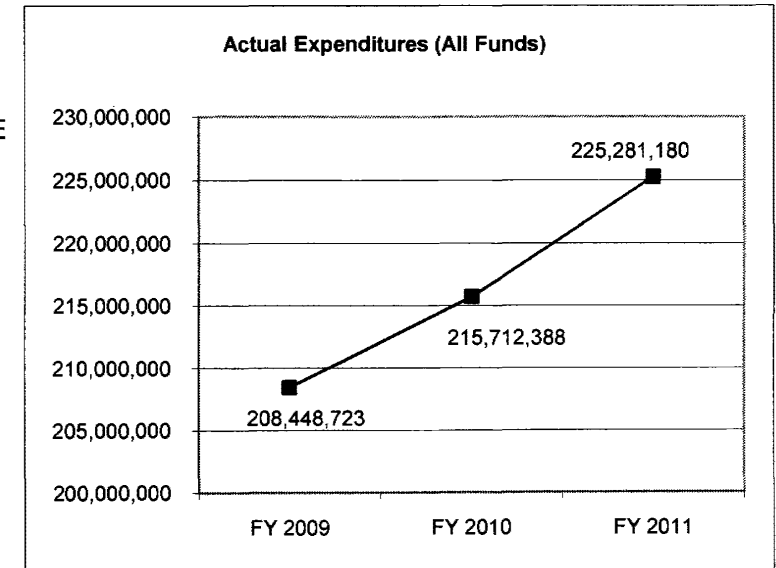
Funding provides Rehabilitation and Specialty services for the fee-for-service MO HealthNet population. The services funded from this core include: audiology/hearing aid; optical; durable medical equipment (DME); ambulance; rehabilitation center; hospice; and comprehensive day rehabilitation. In those regions of the state where MO HealthNet Managed Care has been implemented, participants have Rehab and Specialty services available through the MO HealthNet Managed Care health plans.

## 3. PROGRAM LISTING (list programs included in this core funding)

Rehabilitation and Specialty Services

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	208,454,848	243,332,955	256,329,941	257,635,673 E
Less Reverted (All Funds)	(5,846)	(743,885)	(1,805,846)	N/A
Budget Authority (All Funds)	208,449,002	242,589,070	254,524,095	N/A
Actual Expenditures (All Funds)	208,448,723	215,712,388	225,281,180	N/A
Unexpended (All Funds)	279	26,876,682	29,242,915	N/A
Unexpended, by Fund:				
General Revenue	103	0	69,726	N/A
Federal	176	17,807,457	19,031,359	N/A
Other	0	9,069,225	10,141,830	N/A
	(1)(2)	(3)(4)	(5)(6)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

Estimated "E" appropriation for Ambulance Service Reimbursement Allowance for FY 2010.

(1) Expenditures of \$3,283,111 were paid from the Supplemental Pool.

(2) FY2009: Transfer of Children's residential rehab payments (\$42.1 million) from Children's Division Residential Treatments Services budget to this section.

(3) Agency reserve of \$26,876,682: \$17,807,457 from Federal and \$9,069,225 from Ambulance Service Reimbursement Allowance.

(4) Expenditures of \$15,916,437 were paid from the Supplemental Pool.

(5) Agency reserve of \$13,253,353: \$3,111,523 from Federal and \$10,141,830 from Ambulance Service Reimbursement Allowance.

(6) Expenditures of \$461,393 were paid from the Supplemental Pool.

#### 4. FINANCIAL HISTORY

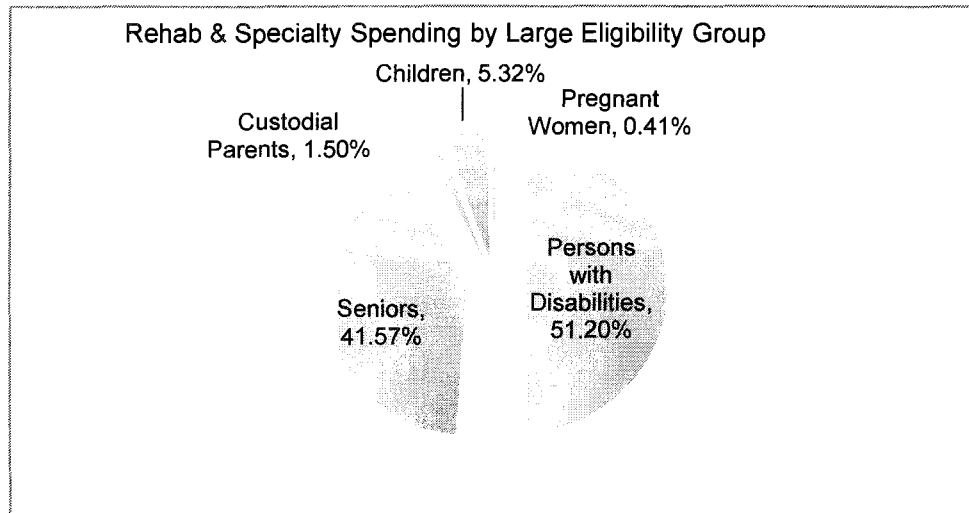
Cost Per Eligible - Per Member Per Month (PMPM)					
	Rehab & Specialty PMPM*	Acute Care PMPM	Total PMPM	Rehab & Specialty Percentage of Acute	Rehab & Specialty Percentage of Total
PTD	\$51.51	\$953.39	\$1,579.47	5.40%	3.26%
Seniors	\$89.42	\$332.63	\$1,293.02	26.88%	6.92%
Custodial Parents	\$3.05	\$403.27	\$416.87	0.76%	0.73%
Children**	\$1.88	\$232.18	\$251.39	0.81%	0.75%
Pregnant Women	\$2.44	\$507.64	\$515.09	0.48%	0.47%

\* Claims only from FY 11 Table 23 Medical Statistics.  
 \*\* CHIP eligibles not included

The Cost per Eligible - Per Member Per Month (PMPM) table provides the total PMPM for each large eligibility group. Health care entities use per member per month calculations as a benchmark to monitor, assess, and manage health care costs. The PMPM metric provides MHD management with a high level aggregate spending metric.

PMPM is calculated by dividing costs by the number of eligibles enrolled. Since caseload growth is accounted for when determining PMPM, the PMPM provides management with a better tool than just comparing overall increases in spending.

PMPM by eligibility group and type of service serves as a baseline for management to determine if cost control interventions are working as intended. Monitoring PMPM amounts allow tracking by a population so that a shift in services is reflected in one metric.



The PMPM table reflects the PMPM amounts for hospital care, acute care, and total. The acute care PMPM is made up of payments for the following services: inpatient, physician/lab/x-ray, outpatient/clinic, drugs, managed care payments, Medicare co-pay/deductibles and other acute services administered by MHD. It does **not** include nursing facilities, in-home services, mental health services and state institutions. By comparing the rehab and specialty PMPM to the acute care PMPM, MHD management can monitor the progress of interventions controlled by MHD management.

The Spending by Large Eligibility Group (left) shows the percentage of spending by each eligibility group for rehab and specialty services. It provides a snapshot of what eligibility groups are receiving the services, as well as the populations impacted by program changes.

Source: Table 23 Medical Statistics for FY 11.

**CORE RECONCILIATION DETAIL**

**DEPARTMENT OF SOCIAL SERVICES**  
**REHAB AND SPECIALTY SERVICES**

**5. CORE RECONCILIATION DETAIL**

	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	EE	0.00	872,000	844,000	0	1,716,000	
	PD	0.00	80,775,861	162,561,313	12,582,499	255,919,673	
	<b>Total</b>	<b>0.00</b>	<b>81,647,861</b>	<b>163,405,313</b>	<b>12,582,499</b>	<b>257,635,673</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	EE	0.00	872,000	844,000	0	1,716,000	
	PD	0.00	80,775,861	162,561,313	12,582,499	255,919,673	
	<b>Total</b>	<b>0.00</b>	<b>81,647,861</b>	<b>163,405,313</b>	<b>12,582,499</b>	<b>257,635,673</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	EE	0.00	872,000	844,000	0	1,716,000	
	PD	0.00	80,775,861	162,561,313	12,582,499	255,919,673	
	<b>Total</b>	<b>0.00</b>	<b>81,647,861</b>	<b>163,405,313</b>	<b>12,582,499</b>	<b>257,635,673</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
REHAB AND SPECIALTY SERVICES								
CORE								
PROFESSIONAL SERVICES	1,443,445	0.00	1,716,000	0.00	1,716,000	0.00	0	0.00
TOTAL - EE	1,443,445	0.00	1,716,000	0.00	1,716,000	0.00	0	0.00
PROGRAM DISTRIBUTIONS	223,837,735	0.00	255,919,673	0.00	255,919,673	0.00	0	0.00
TOTAL - PD	223,837,735	0.00	255,919,673	0.00	255,919,673	0.00	0	0.00
GRAND TOTAL	\$225,281,180	0.00	\$257,635,673	0.00	\$257,635,673	0.00	\$0	0.00
GENERAL REVENUE	\$79,555,410	0.00	\$81,647,861	0.00	\$81,647,861	0.00		0.00
FEDERAL FUNDS	\$143,290,947	0.00	\$163,405,313	0.00	\$163,405,313	0.00		0.00
OTHER FUNDS	\$2,434,823	0.00	\$12,582,499	0.00	\$12,582,499	0.00		0.00



## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Rehab and Specialty Services**

**Program is found in the following core budget(s): Rehab and Specialty Services**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides payment for audiology, optometric, durable medical equipment, ambulance, rehabilitation services, hospice, comprehensive day rehabilitation, disease management and diabetes self-management training for MO HealthNet participants. Unless otherwise noted, the rehabilitation and specialty services are covered only for participants who are under the age of 21, pregnant women, blind persons, or nursing facility residents.*

Audiology/Hearing Aid - This program is intended only to provide hearing aids and related covered services. Persons eligible for reimbursement of the MO HealthNet Hearing Aid Program services include eligible needy children or persons receiving MO HealthNet benefits under a category of assistance for pregnant women, the blind or nursing facility residents. Covered services include: audiological testing, hearing aids, ear molds, hearing aid fitting, hearing aid dispensing/evaluation, post-fitting evaluation, post-fitting adjustments, and hearing aid repairs. All hearing aids and related services must have prior approval except audiometric testing, post-fitting evaluation, post-fitting adjustment, and repairs to hearing aids no longer under warranty. An audiologist consultant gives prior authorization for the claims.

A participant is entitled to one new hearing aid and related services every four years. However, services for children under the EPSDT/HCY program are determined to be whatever is medically necessary. The EPSDT claims are reviewed by the consultant only if rejected by the computer system. Copay is a charge for a small portion of the cost of services and applies to individuals age 19 and over with a few exceptions (foster care children and institutional residents).

Optical - The MO HealthNet Optical Program covers the following types of providers and services: (1) Optometrists - eye examinations, eyeglasses, artificial eyes, and special ophthalmological services; (2) Physicians - eyeglasses, artificial eyes (physician must be enrolled in the Optical program in order to bill for these services); and (3) Opticians - eyeglasses and artificial eyes.

As of June 15, 2009, the MO HealthNet Division (MHD) requires pre-certification for optical services provided to MO HealthNet fee-for-service participants through MHD's web tool, CyberAccessSM.

Participants who are age 20 and under and/or are pregnant, blind, or in a nursing facility are eligible for an eye exam every twelve months. MO HealthNet participants age 21 and over are eligible for an eye exam every twenty-four months. Participants may be eligible for eye exams within the stated time periods if the participant has a .50 diopter change in one or both eyes. MO HealthNet eligible participants are allowed one pair of complete eye glasses every two years. Participants that have a .50 diopter change within the stated time periods may be eligible to receive a new lens. Copay (a charge for a small portion of the cost of the service), and applies to individuals age 19 and over with the exceptions of foster care children and institutional residents. An optometrist is used as a consultant for this program. The consultant reviews prescriptions that do not meet the program criteria.

Durable Medical Equipment (DME) - MO HealthNet reimburses qualified participating DME providers for certain items of durable medical equipment such as: prosthetics, diabetic supplies and equipment, oxygen and respiratory care equipment, ostomy supplies, wheelchairs, wheelchair accessories, labor and repair codes. These items must be for use in the participant's home when ordered in writing by the participant's physician or nurse practitioner and are covered for all MO HealthNet participants.

The following items are covered for MO HealthNet participants: apnea monitors, artificial larynx and related items, augmentative communications devices, canes, crutches, commodes, bed pans, adult incontinence briefs, urinals, CPAP devices, decubitus care equipment, hospital beds, side rails, humidifiers, BiPAP machines, IPPB machines, nebulizers, orthotics, patient lifts and trapeze, scooters, suction pumps, total parenteral nutrition mix, supplies and equipment, and walkers. Although an item is classified as DME, it may not be covered in every instance. Coverage is based on the fact that the item is reasonable and necessary for treatment of an illness or injury, or to improve the functioning of a malformed or permanently inoperative body part, the equipment meets the definition of durable medical equipment or prosthesis, and the equipment is used in the participant's home.

Even though a DME item may serve some useful medical purpose, consideration must be given by the physician and the DME supplier to what extent, if any, it is reasonable for MO HealthNet to pay for the item as opposed to another realistically feasible alternative pattern of care. Consideration should also be given by the physician and the DME provider as to whether the item serves essentially the same purpose as equipment already available to the participant. If two different items each meet the need of the participant, the less expensive item must be employed, all other conditions being equal. Equipment features of an aesthetic or medical nature which are not medically necessary are not reimbursable.

Ambulance - Emergency medical transportation is provided under the ambulance program. Ambulance services are covered if they are emergency services and transportation is made to the nearest appropriate hospital. Certain specified non-emergency but medically necessary ambulance transports are also covered. Reimbursement is provided for the base charge (the lesser of the MO HealthNet maximum allowed amount or billed charge) for patient pick-up and transportation to destination (mileage for transporting a patient beyond the five miles is not included in the base charge), mileage, and ancillary services related to emergency situations. Ambulance services can be provided through ground or air transportation (helicopter/fixed wing) if medically necessary. All MO HealthNet participants are eligible for ambulance services.

Rehabilitation Center - The rehabilitation center program pays for adaptive training of MO HealthNet participants who have prosthetic/orthotic devices. Covered services include: comprehensive evaluation, stump conditioning, prosthetic training, and orthotic training, speech therapy for artificial larynx and occupational therapy related to the prosthetic/orthotic adaption. These procedures are covered by MO HealthNet even when the prosthetic/orthotic service was not provided through the MO HealthNet program.

Augmentative communication devices and training are covered and include the cost of the device, accessories, evaluation, and training. Training is also covered for the following prosthetic devices: artificial arms, artificial legs, artificial larynx, and orthotics.

Hospice - The hospice benefit is designed to meet the needs of patients with a life-limiting illness and to help their families cope with the problems and feelings related to this difficult time. Reimbursement is limited to qualified MO HealthNet enrolled hospice providers rendering services to terminally ill patients who have elected hospice benefits. After the participant elects hospice services, the hospice provides for all care, supplies, equipment, and medicines related to the terminal illness. MO HealthNet reimburses the hospice provider who then reimburses the provider of the services if the services are not provided by the hospice provider. However, hospice services for a child (ages 0-20) may be concurrent with the care related to the curative treatment of the child's condition for which a diagnosis of a terminal illness has been made.

MO HealthNet reimburses for routine home care, continuous home care, general inpatient, inpatient respite, and nursing home room and board, if necessary. Hospice rates are authorized by Section 1814 (l)(1)(C)(ii) of the Social Security Act and provide for an annual increase in the payment rates for hospice care services. The MO HealthNet rates are calculated based on the annual hospice rates established by Medicare. In addition, the Social Security Act also provides for an annual increase in the hospice cap amounts. Nursing Home room and board is reimbursed to the hospice provider at 95% of the nursing home rate on file. The hospice is responsible for paying the nursing home. All MO HealthNet participants are eligible for hospice services.

Comprehensive Day Rehabilitation - This program covers services for certain persons with disabling impairments as the result of a traumatic head injury. It provides intensive, comprehensive services designed to prevent and/or minimize chronic disabilities while restoring the individual to an optimal level of physical, cognitive, and behavioral function within the context of the person, family, and community.

The program emphasizes functional living skills, adaptive strategies for cognitive, memory or perceptual deficits, and appropriate interpersonal skills. These services help to train individuals so that the person can leave the rehabilitation center and re-enter society. Services are designed to maintain and improve the participant's ability to function as independently as possible in the community. Services for this program must be provided in a free-standing rehabilitation center or in an acute hospital setting with space dedicated to head injury rehabilitation. Eligibility for this program is limited to individuals who are under the age of 21, pregnant women, blind persons or nursing home residents. These individuals must receive prior authorization from the MO HealthNet Division. Reimbursement is made for either a full day or a half day of services.

#### Clinical Management Services Program (CMSP)

Through a contract with ACS Heritage, MHD operates an innovative electronic web-based clinical editing process for its point-of-sale pharmacy and medical claims, medical and drug prior authorization, and Drug Utilization Review (DUR) processes. The current CMSP claim processing system allows each claim to be referenced against the participant's claims history including pharmacy, medical, and procedural data (ICD-9 and CPT codes), providing real time data to participating MO HealthNet providers. For patients that meet approval criteria, the claim will be paid automatically. In instances when a phone call is necessary, the hotline call center is available seven days a week, which allows providers prompt access to a paid claim for the requested product or service. In addition to receiving messages regarding the outcome of the processing of claims and the amount to be reimbursed, pharmacy providers receive prospective drug use review alert messages at the time prescriptions are dispensed.

The contract with ACS-Heritage utilizes their CyberAccess<sup>SM</sup> tool to create integrated patient profiles containing prescription information, as well as patient diagnoses and procedure codes for a running 24 months of history. CyberAccess<sup>SM</sup> provides: participant claims history profiles, updated daily, identifying all drugs, procedures, related diagnoses and ordering providers from claims paid by MHD for a rolling 36 month period; and three years of point of sale (POS) pharmacy claims refreshed every ten (10) minutes. MO HealthNet is in the process of adding a precertification module for psychology services.

#### **2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State statute: RSMo. 208.152; Federal law: Social Security Act Section 1905(a)(12) and (18), 1905(o); Federal regulation: 42 CFR 410.40, 418, 431.53, 440.60, 440.120, 440.130 and 440.170.

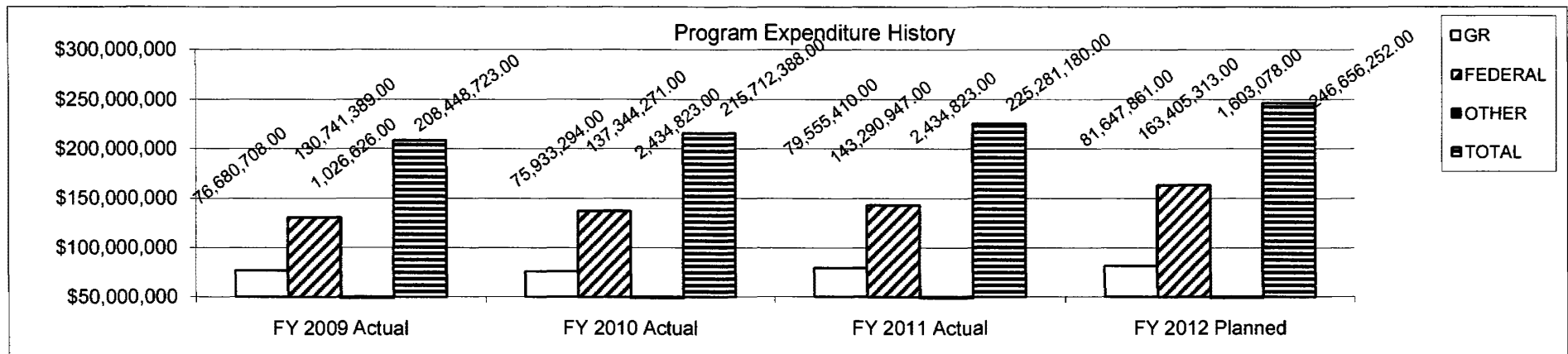
#### **3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 was a blended 63.41% federal match. The state matching requirement is 36.59%.

#### **4. Is this a federally mandated program? If yes, please explain.**

This program is not mandatory for adults but is mandatory for children.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



Reserve: \$10,973,575 Other Funds

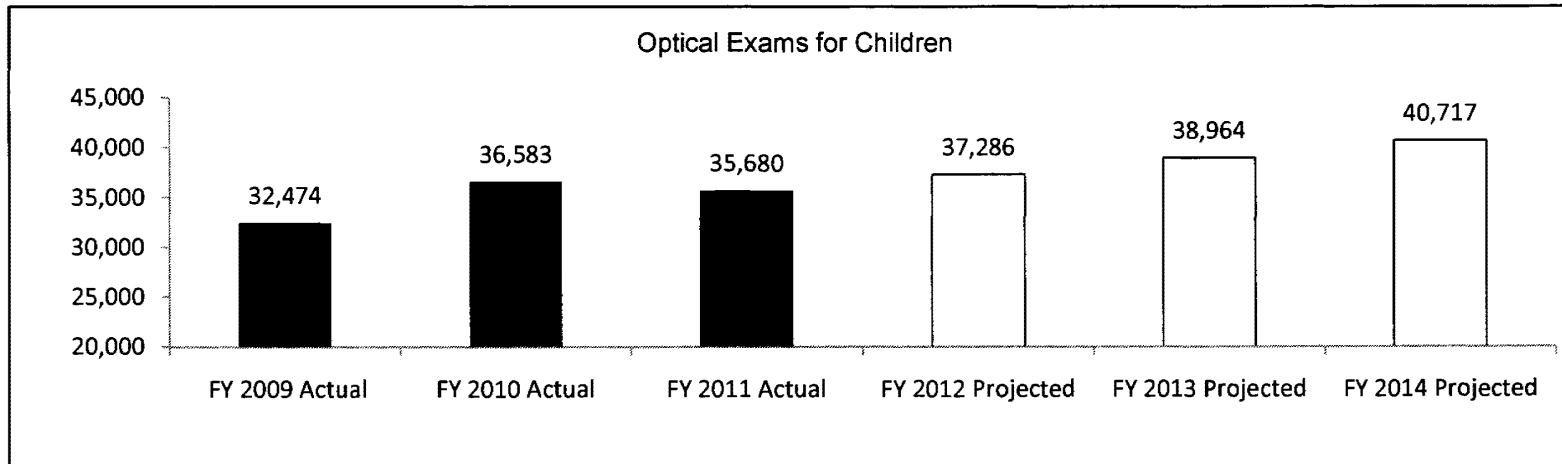
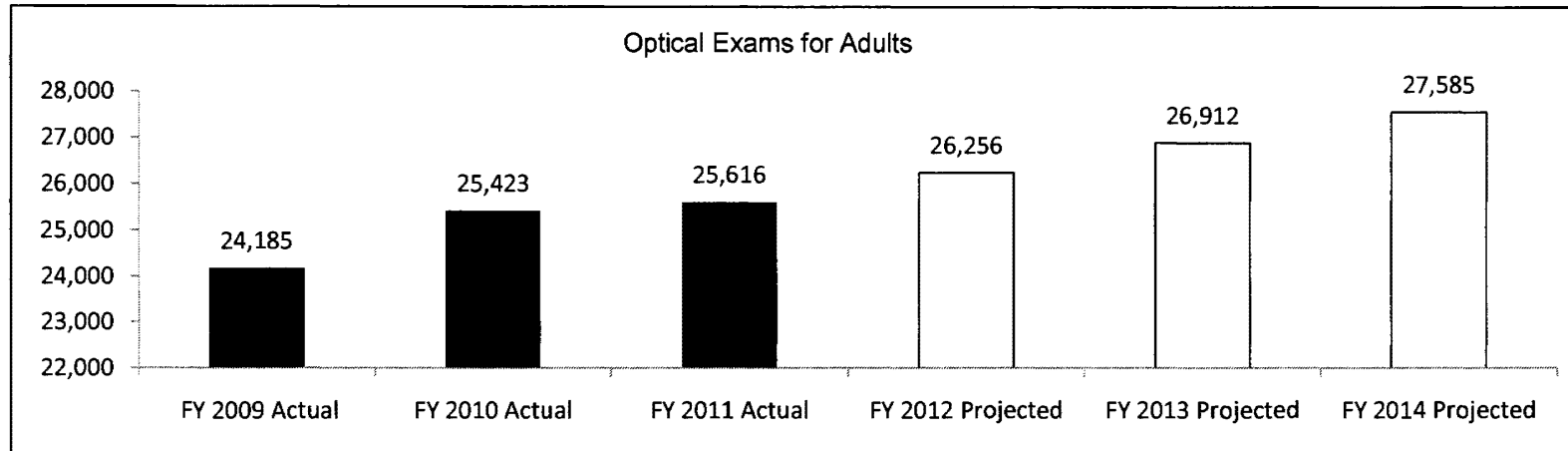
Reverted: \$5,846 Other Funds

**6. What are the sources of the "Other" funds?**

Source of "other" funds for FY 2009: Health Initiatives Fund (0275) and Healthy Families Trust Fund (0625), Source of "other" funds for FY 2010 and FY 2011: Health Initiatives Fund (0275), Healthy Families Trust Fund (0625) and Nursing Facility Federal Reimbursement Allowance (0196). Source of "other" funds for FY 2012: Health Initiatives Fund (0275), Healthy Families Trust Fund (0625), Nursing Facility Federal Reimbursement Allowance (0196) and Ambulance Service Reimbursement Allowance Fund (0958).

**7a. Provide an effectiveness measure.**

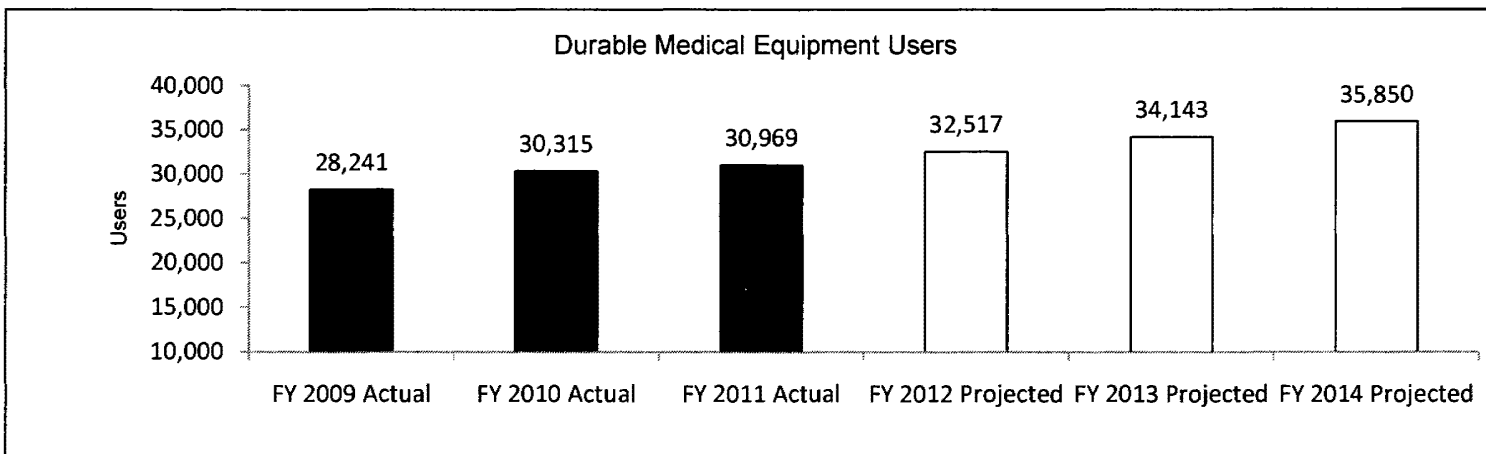
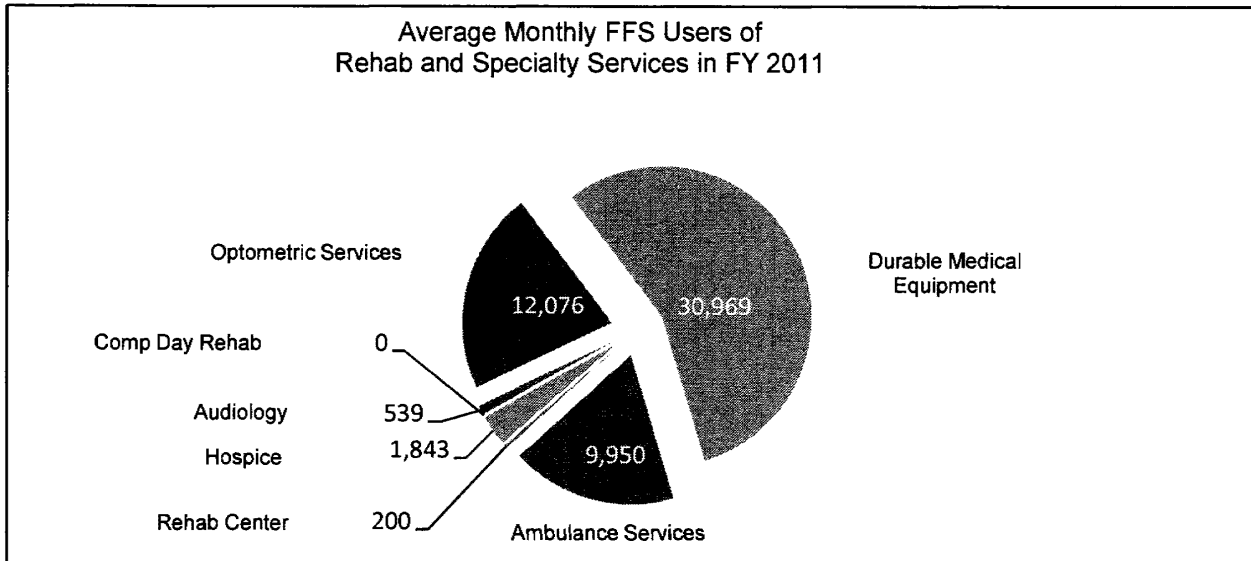
Effectiveness Measure: Provide optical exams to MO HealthNet eligibles. Children and adults who are pregnant, blind, or in a nursing facility are eligible for an eye exam every twelve months. All other adults are eligible for one eye exam every twenty-four months. In state fiscal year 2011, over 25,000 optical examinations were provided to adults, and over 35,500 optical examinations were provided to eligible children.



**7b. Provide an efficiency measure.**

**7c. Provide the number of clients/individuals served, if applicable.**

In regions of the state with access to MO HealthNet Managed Care, rehab and specialty services are available through the MO HealthNet Managed Care health plans for those populations enrolled in Managed Care.



**7d. Provide a customer satisfaction measure, if available.**

**NEW DECISION ITEM  
RANK: 12**

Department: Social Services  
Division: MO HealthNet  
DI Name: Hospice Rate Increase

Budget Unit: 90550C  
DI#: 1886011

**1. AMOUNT OF REQUEST**

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	176,688	298,003		474,691
TRF				
Total	<u>176,688</u>	<u>298,003</u>		<u>474,691</u>
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

**2. THIS REQUEST CAN BE CATEGORIZED AS:**

<input checked="" type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input checked="" type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Inflation	

**3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.**

NDI SYNOPSIS: Funding is needed to apply the annual hospice rate increase as established by Medicare.

The MO HealthNet hospice rates are calculated based on the annual hospice rates established under Medicare, Section 1814(j)(1)(ii). The Act provides for an annual increase in payment rates for hospice care services.

**4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)**

MO HealthNet reimbursement for hospice care is made at one of four predetermined rates for each day in which an individual is under the care of the hospice. The four levels of care are routine home care, continuous home care, inpatient respite care, or general inpatient care. The rate paid for any day may vary, depending on the level of care furnished. Payment rates are adjusted for regional differences in wages.

An increase of 2.56% is requested. An increase of 5.68% was applied to actual FFY 11 units to arrive at the FFY 13 projected units of service. The projected units of service was multiplied by the projected increase in rates to arrive at the total need.

Hospice rates are adjusted in October which is the beginning of the federal fiscal year and is three months into the state's fiscal year. This request includes the three months of FFY 12 that fall within SFY 13 - estimated impact of \$120,457. The twelve-months estimated increase for the FFY 13 rate adjustment is \$472,312. This total is then multiplied by 9/12 to arrive at the SFY 13 impact of \$354,234. The total request for SFY 13 is \$474,691 (3 months totaling \$120,457 plus 9 months totaling \$354,234).

	Total	GR	Federal
July 2012 through Sept. 2012 Increase	120,457	44,027	76,430
Oct. 2012 through June 2013 Increase	354,234	132,661	221,573
Total	\$474,691	\$176,688	\$298,003

FMAP 63.45% Quarter 1 (July through September)

FMAP 62.55% Quarters 2-4 (October through June)



**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	176,688		298,003		0		474,691		
Total PSD	176,688		298,003		0		474,691		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	176,688	0.0	298,003	0.0	0	0.0	474,691	0.0	0

**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

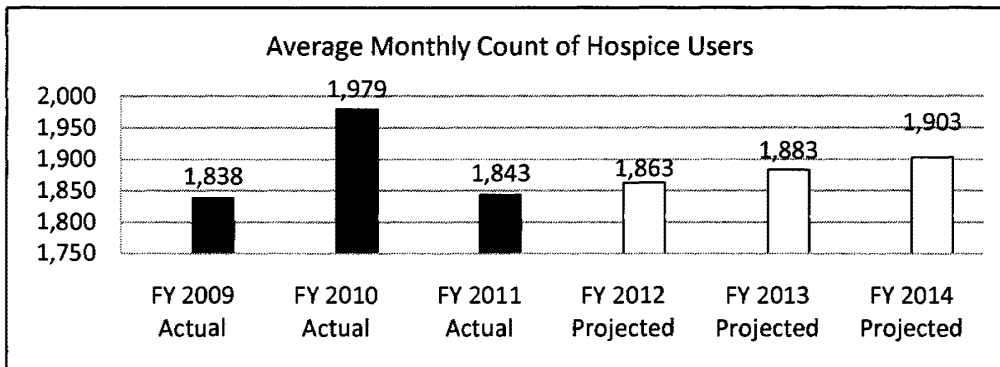
Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

**6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)**

6a. Provide an effectiveness measure.

6b. Provide an efficiency measure.

6c. Provide the number of clients/individuals served, if applicable.



6d. Provide a customer satisfaction measure, if available.

**7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:**

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
REHAB AND SPECIALTY SERVICES								
Hospice Rate Increase - 1886011								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	474,691	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	474,691	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$474,691	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$176,688	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$298,003	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

**NEMT**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN	
<b>NON-EMERGENCY TRANSPORT</b>									
<b>CORE</b>									
PROGRAM-SPECIFIC									
GENERAL REVENUE	10,301,315	0.00	10,923,967	0.00	10,923,967	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	23,232,504	0.00	25,919,527	0.00	25,919,527	0.00	0	0.00	
TOTAL - PD	33,533,819	0.00	36,843,494	0.00	36,843,494	0.00	0	0.00	
<b>TOTAL</b>	<b>33,533,819</b>	<b>0.00</b>	<b>36,843,494</b>	<b>0.00</b>	<b>36,843,494</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	
<b>Caseload Growth - 1886006</b>									
PROGRAM-SPECIFIC									
GENERAL REVENUE	0	0.00	0	0.00	95,685	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	161,394	0.00	0	0.00	
TOTAL - PD	0	0.00	0	0.00	257,079	0.00	0	0.00	
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>257,079</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	
<b>GRAND TOTAL</b>	<b>\$33,533,819</b>	<b>0.00</b>	<b>\$36,843,494</b>	<b>0.00</b>	<b>\$37,100,573</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	

# CORE DECISION ITEM

Department: Social Services  
 Division: MO HealthNet  
 Core: Non-Emergency Medical Transportation (NEMT)

Budget Unit: 90561C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	\$10,923,967	\$25,919,527		\$36,843,494
TRF				
Total	10,923,967	25,919,527		36,843,494
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

## 2. CORE DESCRIPTION

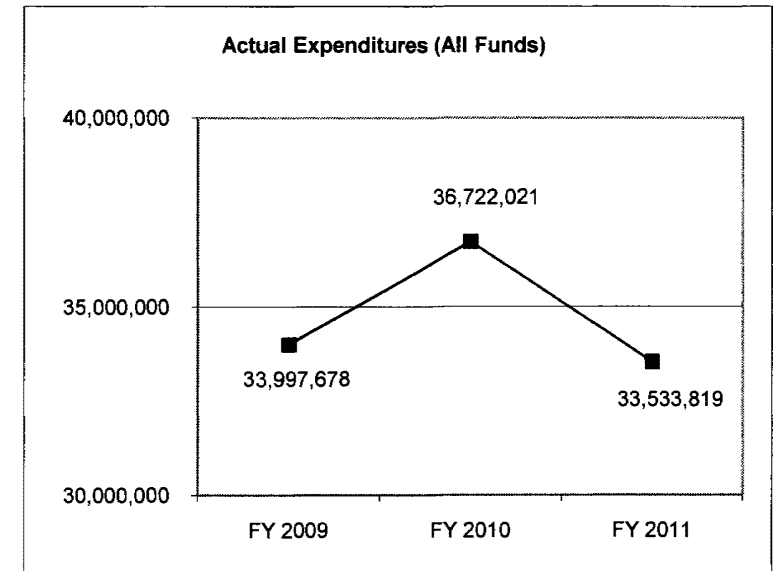
This core request is to provide funding for payments for non-emergency medical transportation.

## 3. PROGRAM LISTING (list programs included in this core funding)

Non-Emergency Medical Transportation (NEMT)

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	40,707,690	38,444,322	35,759,588	36,843,494
Less Reverted (All Funds)	(1,490,144)	(271,640)	0	N/A
Budget Authority (All Funds)	39,217,546	38,172,682	35,759,588	N/A
Actual Expenditures (All Funds)	33,997,678	36,722,021	33,533,819	N/A
Unexpended (All Funds)	5,219,868	1,450,661	2,225,769	N/A
Unexpended, by Fund:				
General Revenue	140,242	32,670	1,095,117	N/A
Federal	5,079,629	1,417,991	1,130,652	N/A
Other	0	0	0	N/A
	(1)	(2)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

(1) Agency reserve of \$128,360 in the Federal Fund.

(2) Expenditures of \$122,694 were paid from the Supplemental Pool.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES**

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**NON-EMERGENCY TRANSPORT**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	10,923,967	25,919,527	0	36,843,494	
	<b>Total</b>	<b>0.00</b>	<b>10,923,967</b>	<b>25,919,527</b>	<b>0</b>	<b>36,843,494</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	10,923,967	25,919,527	0	36,843,494	
	<b>Total</b>	<b>0.00</b>	<b>10,923,967</b>	<b>25,919,527</b>	<b>0</b>	<b>36,843,494</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	10,923,967	25,919,527	0	36,843,494	
	<b>Total</b>	<b>0.00</b>	<b>10,923,967</b>	<b>25,919,527</b>	<b>0</b>	<b>36,843,494</b>	



# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
NON-EMERGENCY TRANSPORT								
CORE								
PROGRAM DISTRIBUTIONS	33,533,819	0.00	36,843,494	0.00	36,843,494	0.00	0	0.00
TOTAL - PD	33,533,819	0.00	36,843,494	0.00	36,843,494	0.00	0	0.00
GRAND TOTAL	\$33,533,819	0.00	\$36,843,494	0.00	\$36,843,494	0.00	\$0	0.00
GENERAL REVENUE	\$10,301,315	0.00	\$10,923,967	0.00	\$10,923,967	0.00		0.00
FEDERAL FUNDS	\$23,232,504	0.00	\$25,919,527	0.00	\$25,919,527	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Non-Emergency Medical Transportation (NEMT)**

**Program is found in the following core budget(s): Non-Emergency Medical Transportation (NEMT)**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides payments for non-emergency medical transportation (NEMT) for MO HealthNet participants who do not have access to free transportation to scheduled MO HealthNet covered services.*

The purpose of the NEMT program is to ensure non-emergency medical transportation to MO HealthNet participants who do not have access to free appropriate transportation (can use free community resources or other free programs) to scheduled MO HealthNet covered services. The participant is to be provided with the most appropriate mode of transportation. As of November 2005, the service is provided as a direct state plan service. The state contracts with a statewide broker and pays monthly capitation payments for each NEMT participant based on which of the four regions of the state in which the participant resides.

Missouri's program utilizes and builds on the existing transportation networks in the state. Managed Care providers are required to include NEMT in their benefit package.

Where appropriate and possible, the MO HealthNet Division enters into cooperative agreements to provide matching MO HealthNet funds for state and local general revenue already being used to transport MO HealthNet participants to medical services. Participants are required to use public entity transportation when available. When they do so, the payments are made by public entities on a per trip basis. By working with existing governmental entities and established transportation providers, NEMT is provided in a cost-effective manner and governmental agencies are able to meet the needs of their constituency.

The MO HealthNet Division works with the following state and local agencies to provide federal matching funds for general revenue used for NEMT services: the Children's Division for children in state care and custody, the Department of Mental Health, public school districts, St. Louis Metro Call-A-Ride, Kansas City Area Transit Authority, the City of Columbia, City Utilities of Springfield, City of Jefferson and the Missouri Kidney Program.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, Federal regulation: 42 CFR 431.53 and 440.170

### 3. Are there federal matching requirements? If yes, please explain.

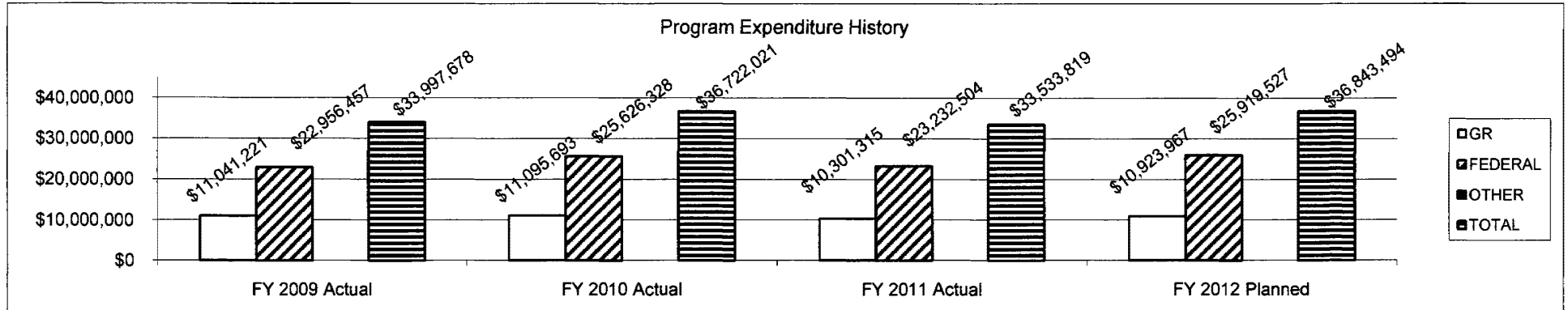
NEMT services receive a federal medical assistance percentage (FMAP) on program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 is a blended 63.41% federal match. The state matching requirement is 36.59%.

Services provided through public entities use state and local general revenue to transport MO HealthNet participants. MO HealthNet provides payment of the federal share for these services. These expenditures earn a 50% federal match.

**4. Is this a federally mandated program? If yes, please explain.**

Yes, state Medicaid programs must assure availability of medically necessary transportation.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**

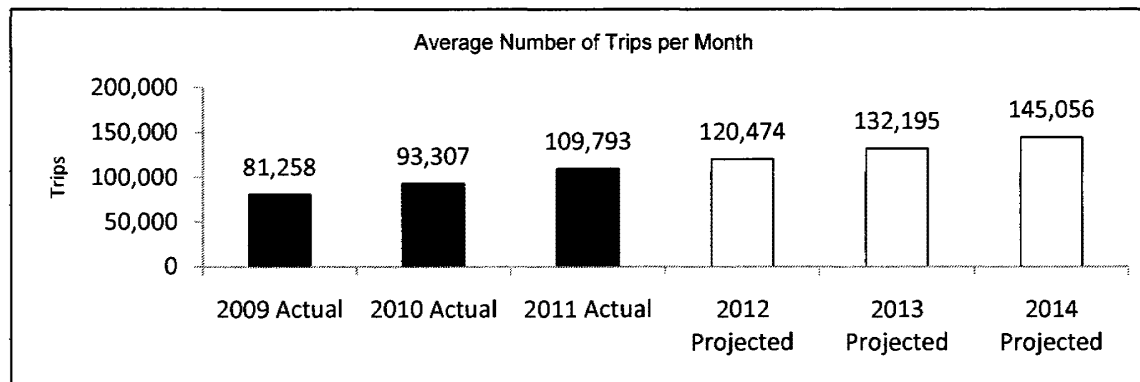


**6. What are the sources of the "Other" funds?**

N/A

**7a. Provide an effectiveness measure.**

Effectiveness Measure: Provide non-emergency medical transportation to MO HealthNet participants to increase access to health care. There were 93,307 NEMT trips per month provided through the contractor in SFY 2010.



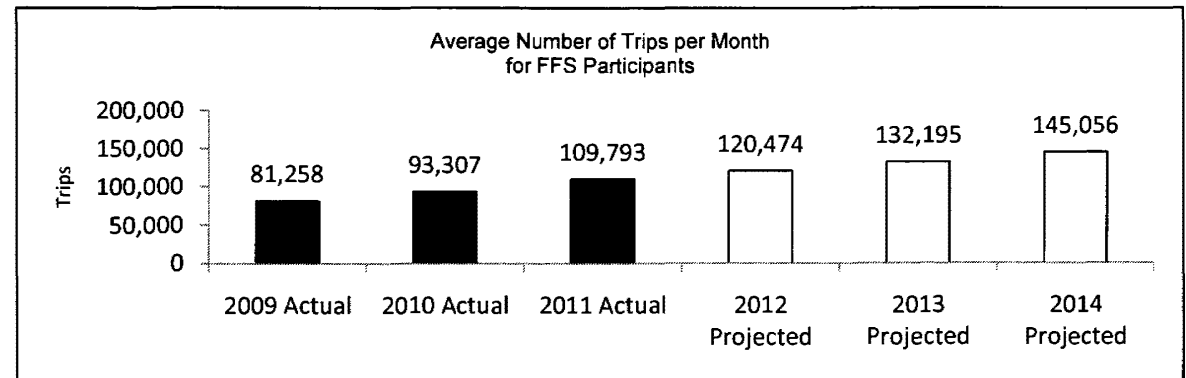
**7b. Provide an efficiency measure.**

Efficiency Measure: MO HealthNet paid a total of \$33,362,614 in SFY 2011 for NEMT services.

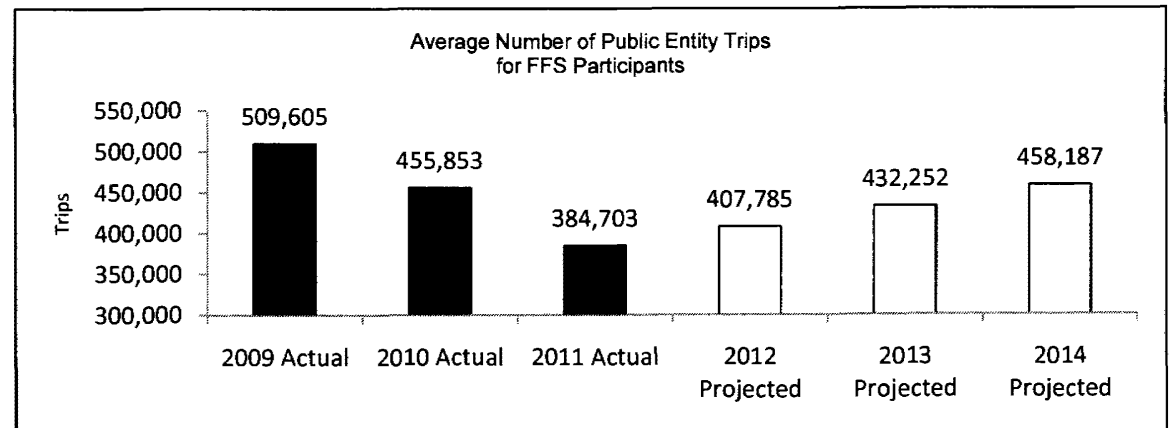
NEMT Payments				
Provider	SFY08	SFY09	SFY10	SFY11
Private Contractor	\$ 29,834,820	\$29,841,994	\$30,985,403	\$27,970,416
Public Entities (federal only)	\$ 5,205,740	\$ 4,155,684	\$ 5,736,618	\$ 5,392,198
TOTAL	\$35,040,560	\$33,997,678	\$36,722,021	\$33,362,614

**7c. Provide the number of clients/individuals served, if applicable.**

Non-emergency medical transportation is available to MO HealthNet participants who are eligible under a federal aid category. Those participating under a state only funded category or under a Title XXI expansion category are not eligible for NEMT services. Participants in Managed Care receive the NEMT benefit but are not included in the chart.



Public entities have interagency agreements with the MO HealthNet Division to provide access to transportation services for a specific group of participants, such as dialysis patients, persons with disabilities, or the elderly. Public entities use state and local dollars to draw down the federal matching funds.



Prior year numbers have been updated with more accurate data.

**7d. Provide a customer satisfaction measure, if available.**

The proportion of complaints to the number of trips provided by the contractor remains below 1%.

NEMT Complaint to Trip Ratio (Contractor Trips)						
	Actual			Projection		
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Trips	975,341	1,119,686	1,228,608	1,348,140	1,479,300	1,623,236
Complaints	3,180	2,606	2,613	2,620	2,627	2,883
% Complaints	<1%	<1%	<1%	<1%	<1%	<1%

# **Managed Care**

# FY13 Department of Social Services Report #9

# DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>MANAGED CARE</b>								
<b>CORE</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	260,111,748	0.00	303,877,638	0.00	303,877,638	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	659,448,528	0.00	731,080,298	0.00	731,080,298	0.00	0	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	93,533,441	0.00	93,533,441	0.00	93,533,441	0.00	0	0.00
MO HEALTHNET MANAGED CARE ORG	560	0.00	1	0.00	1	0.00	0	0.00
HEALTH INITIATIVES	7,813,428	0.00	8,055,080	0.00	8,055,080	0.00	0	0.00
HEALTHY FAMILIES TRUST	4,447,110	0.00	4,447,110	0.00	4,447,110	0.00	0	0.00
LIFE SCIENCES RESEARCH TRUST	7,272,544	0.00	7,272,544	0.00	7,272,544	0.00	0	0.00
TOTAL - PD	1,032,627,359	0.00	1,148,266,112	0.00	1,148,266,112	0.00	0	0.00
<b>TOTAL</b>	<b>1,032,627,359</b>	<b>0.00</b>	<b>1,148,266,112</b>	<b>0.00</b>	<b>1,148,266,112</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Caseload Growth - 1886006</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	2,362,853	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	3,985,489	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	6,348,342	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>6,348,342</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Managed Care Actuarial Increas - 1886008</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	21,964,228	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	37,047,670	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	59,011,898	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>59,011,898</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>

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# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>MANAGED CARE</b>								
Medicaid Primary Care Rate Inc - 1886016								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	15,335,897	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	15,335,897	0.00	0	0.00
TOTAL	0	0.00	0	0.00	15,335,897	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$1,032,627,359</b>	<b>0.00</b>	<b>\$1,148,266,112</b>	<b>0.00</b>	<b>\$1,228,962,249</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Managed Care

Budget Unit: 90551C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request				
	GR	Federal	Other	Total	
PS					
EE					
PSD	303,877,638	731,080,298	113,308,176	1,148,266,112	E
TRF					
Total	<u>303,877,638</u>	<u>731,080,298</u>	<u>113,308,176</u>	<u>1,148,266,112</u>	E

FTE 0.00

<b>Est. Fringe</b>	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

	FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total	
PS					
EE					
PSD					
TRF					
Total					

FTE

<b>Est. Fringe</b>	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: MO HealthNet Managed Care Organization Reimb Allow Fund (0160)  
Health Initiatives Fund (HIF) (0275)  
Federal Reimbursement Allowance Fund (FRA) (0142)  
Healthy Families Trust Fund (0625)  
Life Sciences (0763)

Note: An "E" is requested for \$1 Managed Care Organization Reimbursement Allowance Fund

## 2. CORE DESCRIPTION

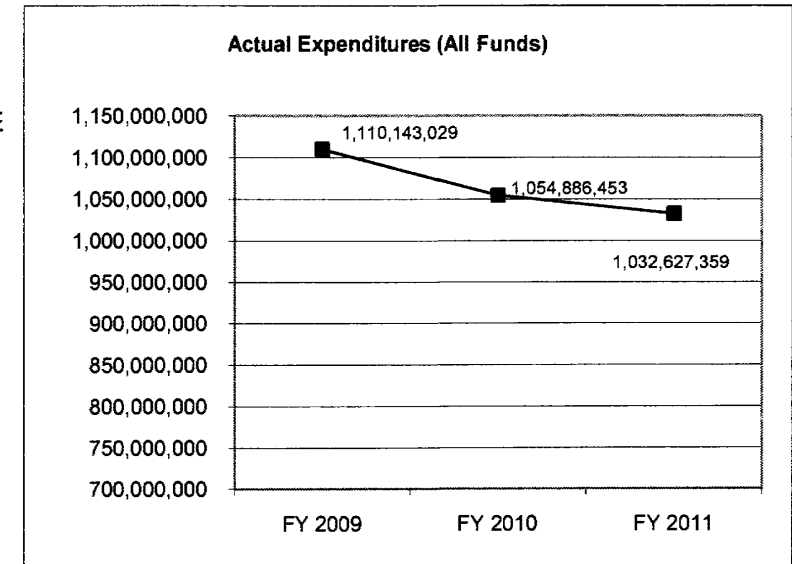
This core request is for the continued funding of the Managed Care program to provide health care services to the MO HealthNet managed care population.

## 3. PROGRAM LISTING (list programs included in this core funding)

Managed Care

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.	
Appropriation (All Funds)	1,116,494,035	1,055,128,105	1,068,925,731	1,148,266,112	E
Less Reverted (All Funds)	(6,308,415)	(241,652)	(5,241,652)	N/A	
Budget Authority (All Funds)	1,110,185,620	1,054,886,453	1,063,684,079	N/A	
Actual Expenditures (All Funds)	1,110,143,029	1,054,886,453	1,032,627,359	N/A	
Unexpended (All Funds)	42,591	0	31,056,720	N/A	
Unexpended, by Fund:					
General Revenue	0	0	0	N/A	
Federal	0	0	31,056,720	N/A	
Other	42,591	0	0	N/A	
	(1)	(2)	(3)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

Estimated "E" appropriation for the Managed Care Organization Reimbursement Allowance fund appropriation.

(1) Expenditures of \$17,865,128 were paid from the Supplemental Pool.

(2) "E" increase of \$3,000,305 in the Managed Care Organization Reimbursement Allowance Fund appropriation.

(3) Agency reserve of \$8,734,377 in federal funds; Expenditures of \$4,718,850 were paid from the Supplemental Pool.

#### 4. FINANCIAL HISTORY

Cost Per Eligible - Per Member Per Month (PMPM)					
	Managed Care PMPM***	Acute Care PMPM	Total PMPM	Managed Care Percentage of Acute	Managed Care Percentage of Total
PTD	\$0.00	\$953.39	\$1,579.47	0.00%	0.00%
Seniors	\$0.00	\$332.63	\$1,293.02	0.00%	0.00%
Custodial Parents	\$191.32	\$403.27	\$416.87	47.44%	45.89%
Children**	\$114.79	\$232.18	\$251.39	49.44%	45.66%
Pregnant Women	\$157.25	\$507.64	\$515.09	30.98%	30.53%

\* Claims only from FY 11 Table 23 Medical Statistics. Does not include add-on payments.  
 \*\* CHIP eligibles not included  
 \*\*\* Includes EPSDT services

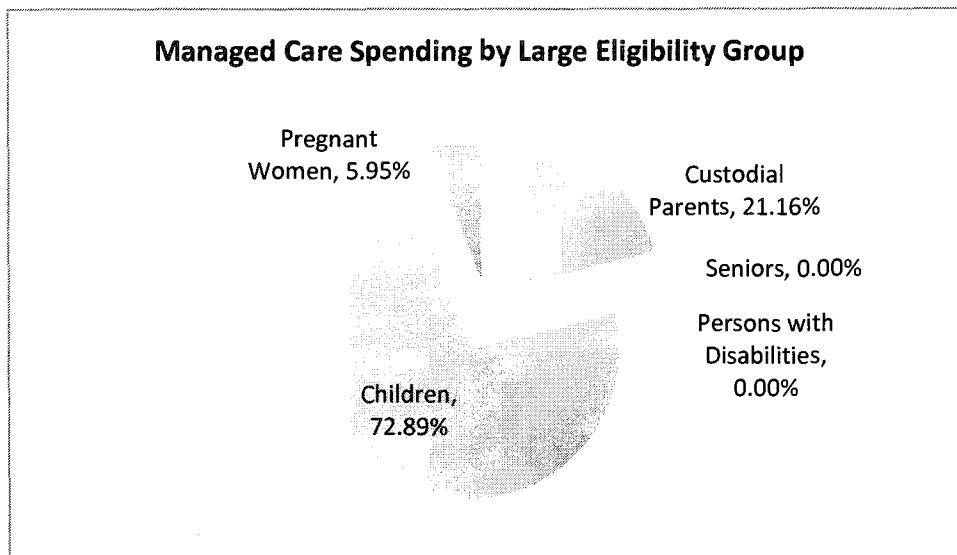
The Cost per Eligible - Per Member Per Month (PMPM) table provides the total PMPM for each large eligibility group. Health care entities use per member per month calculations as a benchmark to monitor, assess, and manage health care costs. The PMPM metric provides MHD management with a high level aggregate spending metric.

PMPM is calculated by dividing costs by the number of eligibles enrolled. Since caseload growth is accounted for when determining PMPM, the PMPM provides management with a better tool than just comparing overall increases in spending.

PMPM by eligibility group and type of service serves as a baseline for management to determine if cost control interventions are working as intended. Monitoring PMPM amounts allow tracking by a population so that a shift in services is reflected in one metric.

The PMPM table reflects the PMPM amounts for managed care, acute care, and total. The acute care PMPM is made up of payments for the following services: inpatient, physician/lab/x-ray, outpatient/clinic, pharmacy, managed care payments, Medicare co-pay/deductibles, dental and other acute services administered by MHD. It does **not** include nursing facilities, in-home services, mental health services and state institutions. By comparing the managed care PMPM to the acute care PMPM, MHD management can monitor the progress of interventions controlled by MHD management.

The Spending by Large Eligibility Group (left) shows the percentage of spending by each eligibility group for managed care. It provides a snapshot of what eligibility groups are enrolled in managed care, as well as the populations impacted by program changes.



Source: Table 23 Medical Statistics for Fiscal Year 2011

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES**

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**MANAGED CARE**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	303,877,638	731,080,298	113,308,176	1,148,266,112	
	<b>Total</b>	<b>0.00</b>	<b>303,877,638</b>	<b>731,080,298</b>	<b>113,308,176</b>	<b>1,148,266,112</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	303,877,638	731,080,298	113,308,176	1,148,266,112	
	<b>Total</b>	<b>0.00</b>	<b>303,877,638</b>	<b>731,080,298</b>	<b>113,308,176</b>	<b>1,148,266,112</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	303,877,638	731,080,298	113,308,176	1,148,266,112	
	<b>Total</b>	<b>0.00</b>	<b>303,877,638</b>	<b>731,080,298</b>	<b>113,308,176</b>	<b>1,148,266,112</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>MANAGED CARE</b>								
<b>CORE</b>								
PROGRAM DISTRIBUTIONS	1,032,627,359	0.00	1,148,266,112	0.00	1,148,266,112	0.00	0	0.00
TOTAL - PD	1,032,627,359	0.00	1,148,266,112	0.00	1,148,266,112	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$1,032,627,359</b>	<b>0.00</b>	<b>\$1,148,266,112</b>	<b>0.00</b>	<b>\$1,148,266,112</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$260,111,748	0.00	\$303,877,638	0.00	\$303,877,638	0.00		0.00
FEDERAL FUNDS	\$659,448,528	0.00	\$731,080,298	0.00	\$731,080,298	0.00		0.00
OTHER FUNDS	\$113,067,083	0.00	\$113,308,176	0.00	\$113,308,176	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Managed Care**

**Program is found in the following core budget(s): Managed Care**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides funding for capitation payments to managed care plans on behalf of MO HealthNet participants enrolled in managed care.*

The MO HealthNet Division operates an HMO-style managed care program, MO HealthNet Managed Care. MO HealthNet Managed Care health plans contract with the state and are paid a monthly capitation payment for providing services for each enrollee. Participation in MO HealthNet Managed Care is mandatory for certain MO HealthNet eligibility groups within the regions in operation. The mandatory groups are: MO HealthNet for Families-Adults and Children, MO HealthNet for Children, Refugees, MO HealthNet for Pregnant Women, Children in State Care and Custody, and Children's Health Insurance Program (CHIP). Those participants who receive Supplemental Security Income (SSI), meet the SSI medical disability definition, or get adoption subsidy benefits may stay in MO HealthNet Managed Care or may choose to receive services on a fee-for-service basis. The MO HealthNet Managed Care program has been operating in the Eastern Region since September 1, 1995, in the Central Region since March 1, 1996, and in the Western Region since January 1, 1997. Effective January 1, 2008 the state introduced the MO HealthNet Managed Care program in seventeen counties contiguous to the existing three MO HealthNet Managed Care regions.

The MO HealthNet Managed Care program is subject to an approved federal 1915(b) waiver and an approved CHIP State Plan Amendment. These include a cost projection and a budget neutrality projection. An independent evaluation of the MO HealthNet Managed Care program is required with respect to access to care and quality of services that must be submitted to the Centers for Medicare and Medicaid Services. At the end of the waiver period or at prescribed intervals within the waiver period, the state must demonstrate that their waiver cost projections and budget neutrality projections are reasonable and consistent with statute, regulation and guidance.

Objectives of the MO HealthNet Managed Care program include cost effectiveness, quality of care, contract compliance, and member satisfaction.

Services: In MO HealthNet Managed Care most enrollees receive all the services that the fee-for-service program offers. Examples of services included in the capitation payment paid to health plans are: hospital, physician, emergency medical services, EPSDT services, family planning services, dental, optical, audiology, personal care, adult day health care, and mental health services. Certain services are provided on a fee-for-service basis outside of the capitation payment such as pharmacy services, transplants, and school-based therapy. Department of Health and Senior Services testing services (tests on newborns), certain mental health services, including ICF/MR, community psychiatric rehabilitation services, CSTAR services, smoking cessation, and mental health services for children in care and custody are also offered on a fee-for-service basis.

Improvements Over Fee-For-Service: MO HealthNet Managed Care gives MO HealthNet participants a number of advantages over traditional fee-for-service MO HealthNet. Each MO HealthNet Managed Care participant chooses a MO HealthNet Managed Care health plan and a primary care provider from within the network of the health plan. Managed Care participants are guaranteed access to primary care and other services as needed.

MO HealthNet Managed Care health plans must ensure that routine exams are scheduled within thirty days, urgent care within twenty-four hours, and emergency services must be available at all times. MO HealthNet Managed Care health plans must ensure that children receive all EPSDT exams (complete physicals on a regular schedule), are fully immunized, and receive any medically necessary service. MO HealthNet Managed Care health plans are required to provide case management to ensure that enrollee services, especially children's and pregnant women's are properly coordinated.

MO HealthNet Managed Care provides the means to control costs, but more importantly provides the means to ensure access, manage and coordinate benefits, and monitor quality of care and outcomes.

**Quality Assessment:** The purpose of quality assessment is to assess the quality of services in the MO HealthNet Managed Care program. Quality assessment utilizes a variety of methods and tools to measure outcomes of services provided. The goal is to monitor health care services provided to MO HealthNet Managed Care members by the MO HealthNet Managed Care health plans, and comply with federal, state and contract requirements. The MO HealthNet Managed Care health plans must meet program standards for quality improvement, systems, member services, provider services, recordkeeping, organizational structure, adequacy of personnel, access standards, and data reporting as outlined in the MO HealthNet Managed Care contracts. Quality assessment measures are taken from the Health Plan Employer and Data Information Set (HEDIS) and other internally developed measurements. HEDIS is a strong public/private effort that includes a standardized set of measures to assess and encourage the continual improvement in the quality of health care. Specifically, Medicaid HEDIS includes additional quality and access measures which respond more directly to needs of women and children who make up the majority of MO HealthNet Managed Care participants. HEDIS is intended to be used collaboratively by the state agency and the MO HealthNet Managed Care health plans to:

- ♦ Provide the state agency with information on the performance of the contracted MO HealthNet Managed Care health plans;
- ♦ Assist health plans in quality improvement efforts;
- ♦ Support emerging efforts to inform MO HealthNet clients about managed care plan performance; and
- ♦ Promote standardization of health plan reporting across the public and private sectors.

An annual report is provided with significant outcomes measured including the following:

- ♦ Member complaints and grievances including actions taken and reasons for members changing MO HealthNet Managed Care health plans;
- ♦ Utilization review including inpatient/outpatient visits for both physical and mental health;
- ♦ Outcome indicators such as diabetes, asthma, low birth weight and mortality;
- ♦ EPSDT activities (children's health services) such as the number of well child visits provided; and
- ♦ Prenatal activities and services provided.

**National Committee for Quality Assurance (NCQA) Accreditation:** Effective October 1, 2011, the Managed Care health plans must be NCQA accredited at a level of "accredited" or better for the MO HealthNet product. The MCOs must maintain such accreditation thereafter and throughout the duration of the contract. The state of Missouri will require all future MO HealthNet Managed Care contractors to be NCQA accredited.

**Contract Compliance:** Along with quality assessment, monitoring MO HealthNet Managed Care health plan compliance to contractual requirements is a primary method to measure whether the goals of managed care are being met. Contractual compliance monitoring begins with the issuance of the Request for Proposal (RFP) and continues throughout the contract. Contract compliance is measured through a variety of methods. The MO HealthNet Division has a relationship with the Missouri Department of Insurance, Financial Institutions and Professional Registration to analyze MO HealthNet Managed Care health plan provider networks in accordance with 20 CSR 400-7.095 to ensure that the network is adequate to meet the needs of enrollees.

**Member Satisfaction:** Member satisfaction with the MO HealthNet Managed Care health plans is another method for measuring success of the MO HealthNet Managed Care program. An initial measurement is how many members actually choose their MO HealthNet Managed Care health plan versus MO HealthNet assigning them to MO HealthNet Managed Care health plans. MO HealthNet Managed Care has a high voluntary choice percentage. Since the inception of the MO HealthNet Managed Care program, approximately 10% of enrollees are randomly assigned. Reporting has been developed to continuously monitor how many participants initially choose their MO HealthNet Managed Care health plans as well as which health plans are chosen. Other reporting monitors participants' transfer requests among MO HealthNet Managed Care health plans to identify health plans that have particular problems keeping their participants. MO HealthNet also looks at the number of calls coming into our participant and provider hotlines to assess problem areas with health plans. MO HealthNet Managed Care health plans submit enrollee satisfaction data to the Department of Health and Senior Services in accordance with 19 CSR 10-5.010.

**Managed Care Rebid:** MO HealthNet is in the process of rebidding the current Managed Care contracts. The division plans to release the managed care RFP during the Fall of 2011 with responses due in December, 2011. The new contracts will start July 1, 2012.

**2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State statute: RSMo. 208.166; Federal law: Social Security Act Sections 1902(a)(4), 1903(m), 1915(b), 1932; Federal Regulations: 42 CFR 438 and 412.106.

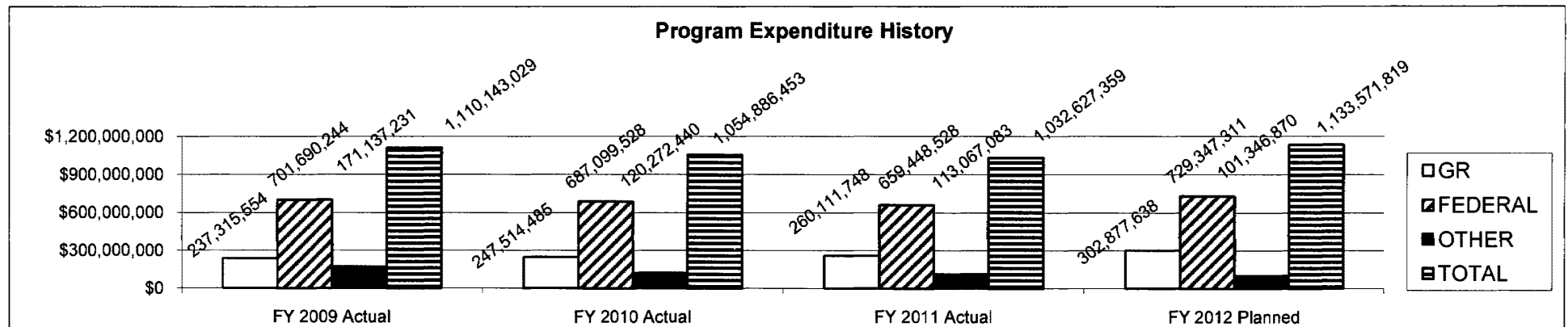
**3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 is a blended 63.41% federal match. The state matching requirement is 36.59%.

**4. Is this a federally mandated program? If yes, please explain.**

MO HealthNet Managed Care covers most services available to fee-for-service participants. As such, both mandatory and non-mandatory services are included. Services not included in MO HealthNet Managed Care are available on a fee-for-service basis.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



FY12 Reverted: \$1,000,000 General Revenue Fund and \$241,652 Other Funds .

FY12 Reserved: \$1,732,987 Federal Funds and \$11,719,654 Other Funds

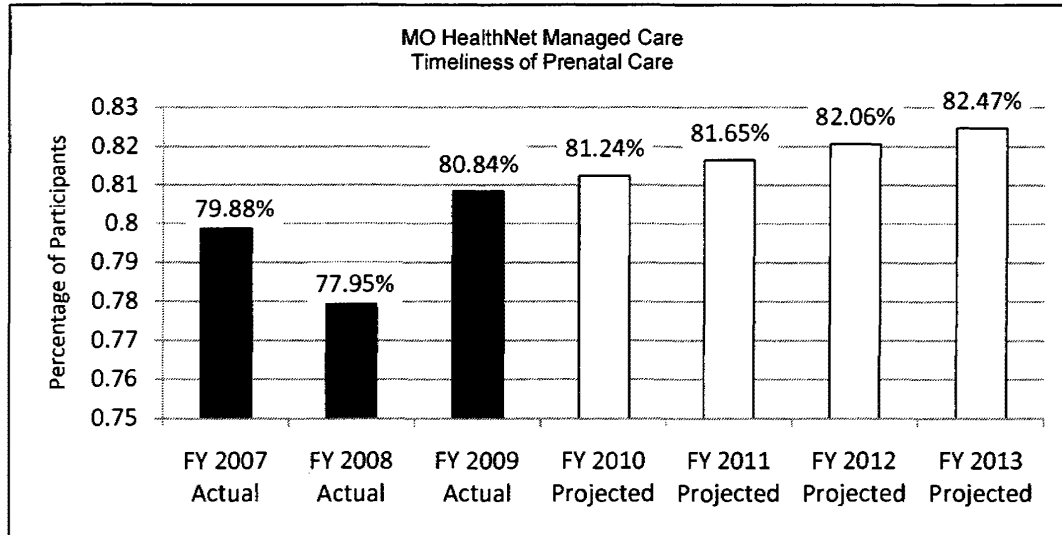


## 6. What are the sources of the "Other" funds?

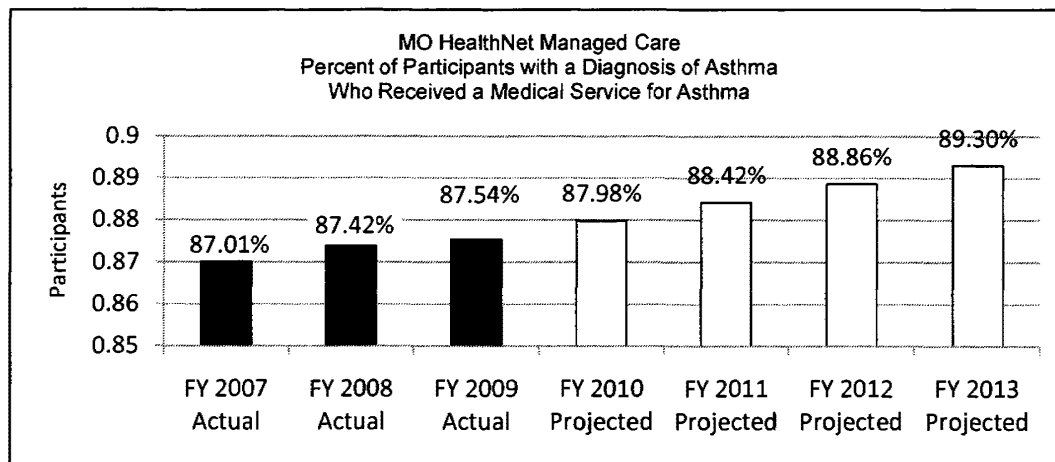
Federal Reimbursement Allowance Fund (0142), Health Initiatives Fund (0275), Medicaid Managed Care Organization Reimbursement Allowance Fund (0160), Healthy Families Trust (0625) and for FY 11 Life Sciences Research Trust Fund (0763).

## 7a. Provide an effectiveness measure.

Prenatal care is important for monitoring the progress of pregnancy and to identify risk factors for the mother or baby before they become serious and lead to poor outcomes and more expensive health care costs. The diagnosis and treatment of chronic conditions also reduces more expensive health care costs that could result when conditions are left untreated.



Effectiveness Measure 1: Increase the percentage of women receiving early prenatal care. The percentage of women who received prenatal care within the first trimester or within 42 days of enrollment in a health plan was nearly 81% in FY 2009.

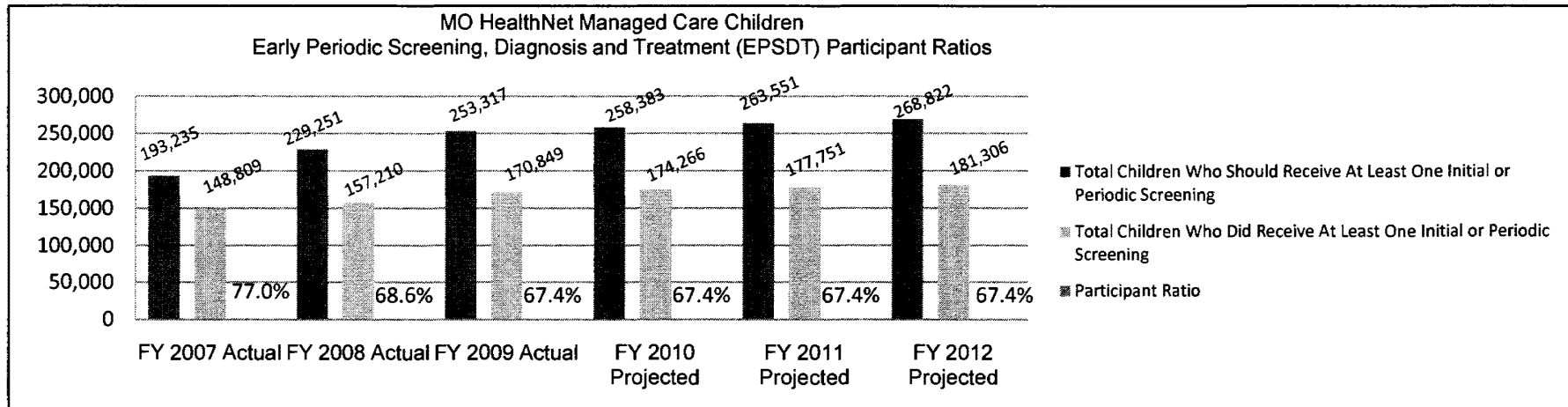


Effectiveness Measure 2: Increase the percentage of participants with chronic conditions who receive treatment for their condition. The percentage of participants with a diagnosis of asthma who received a medical service for asthma was 87.54% in FY 2009.

**7b. Provide an efficiency measure.**

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program is a comprehensive, primary and preventive health care program for MO HealthNet eligible children and youth under the age of 21 years. The program provides early and periodic medical/dental screenings, diagnosis and treatment to correct or ameliorate defects and chronic conditions found during the screening. The chart below does not include CHIP children.

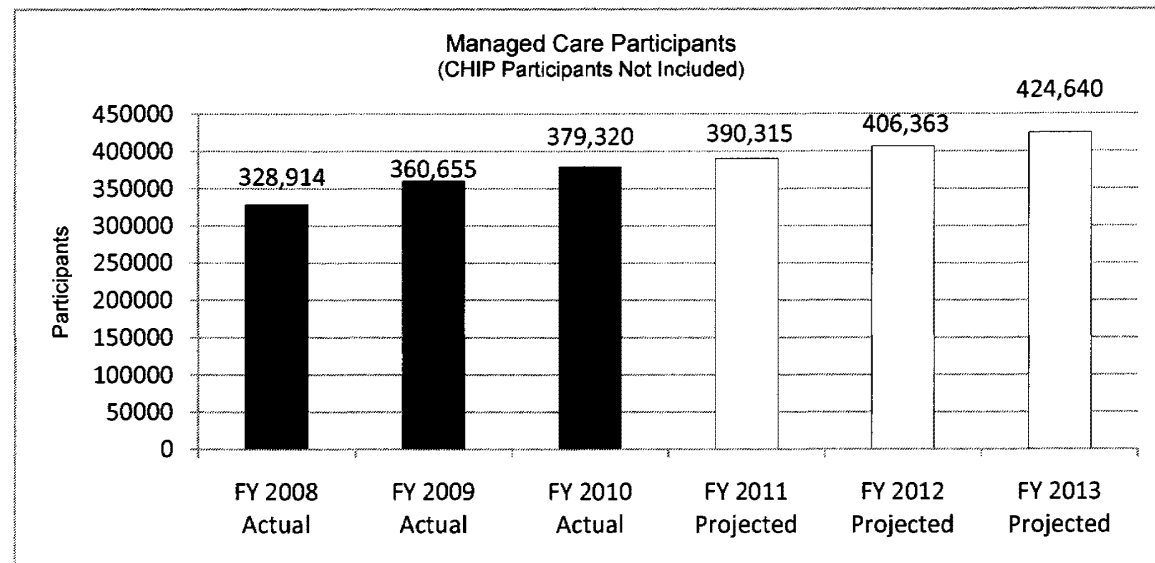
Efficiency Measure: Increase the ratio of children who receive an EPSDT service.



**7c. Provide the number of clients/individuals served, if applicable.**

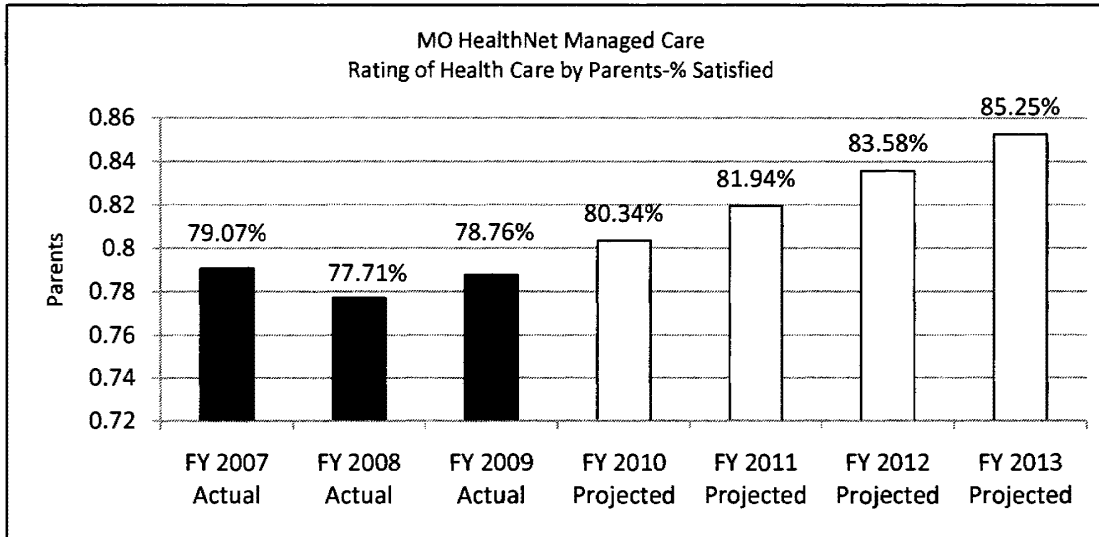
Participation in MO HealthNet Managed Care for those areas of the state where it is available is mandatory for these eligibility categories:

- \* MO HealthNet for Families;
- \* MO HealthNet for Kids;
- \* Refugees;
- \* MO HealthNet for Pregnant Women;
- \* Children in state care and custody; and
- \* CHIP.



**7d. Provide a customer satisfaction measure, if available.**

When parents were asked if they were satisfied with the health care their child received through their MO HealthNet Managed Care plan, nearly 79% responded that they were satisfied in 2009.



Customer Satisfaction Measure: Increase the percentage of parents who were satisfied with the health care their child received through MO HealthNet Managed Care.

# **Hospital Care**

# FY13 Department of Social Services Report #9

# DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>HOSPITAL CARE</b>								
<b>CORE</b>								
EXPENSE & EQUIPMENT								
TITLE XIX-FEDERAL AND OTHER	1,444,334	0.00	215,000	0.00	215,000	0.00	0	0.00
UNCOMPENSATED CARE FUND	287,495	0.00	0	0.00	0	0.00	0	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	802,431	0.00	215,000	0.00	215,000	0.00	0	0.00
TOTAL - EE	2,534,260	0.00	430,000	0.00	430,000	0.00	0	0.00
PROGRAM-SPECIFIC								
GENERAL REVENUE	15,249,439	0.00	24,567,406	0.00	24,567,406	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	481,550,036	0.00	582,439,659	0.00	552,439,659	0.00	0	0.00
UNCOMPENSATED CARE FUND	23,786,027	0.00	33,848,436	0.00	33,848,436	0.00	0	0.00
THIRD PARTY LIABILITY COLLECT	1,062,735	0.00	1,062,735	0.00	1,062,735	0.00	0	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	184,881,310	0.00	205,498,958	0.00	185,498,958	0.00	0	0.00
HEALTH INITIATIVES	2,713,264	0.00	8,997,179	0.00	8,997,179	0.00	0	0.00
HEALTHY FAMILIES TRUST	42,731,431	0.00	42,731,431	0.00	42,731,431	0.00	0	0.00
TOTAL - PD	751,974,242	0.00	899,145,804	0.00	849,145,804	0.00	0	0.00
<b>TOTAL</b>	<b>754,508,502</b>	<b>0.00</b>	<b>899,575,804</b>	<b>0.00</b>	<b>849,575,804</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Caseload Growth - 1886006</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	6,686,121	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	11,277,665	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	17,963,786	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>17,963,786</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$754,508,502</b>	<b>0.00</b>	<b>\$899,575,804</b>	<b>0.00</b>	<b>\$867,539,590</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Hospital Care

Budget Unit: 90552C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE		215,000	215,000	430,000
PSD	24,567,406	552,439,659	272,138,739	849,145,804
TRF				
Total	<b>24,567,406</b>	<b>552,654,659</b>	<b>272,353,739</b>	<b>849,575,804</b>
FTE	0.00	0.00	0.00	0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Uncompensated Care Fund (UCF) (0108)  
Federal Reimbursement Allowance Fund (FRA) (0142)  
Health Initiatives Fund (HIF) (0275)  
Third Party Liability Collections Fund (TPL) (0120)  
Healthy Families Trust Fund (0625)

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

## 2. CORE DESCRIPTION

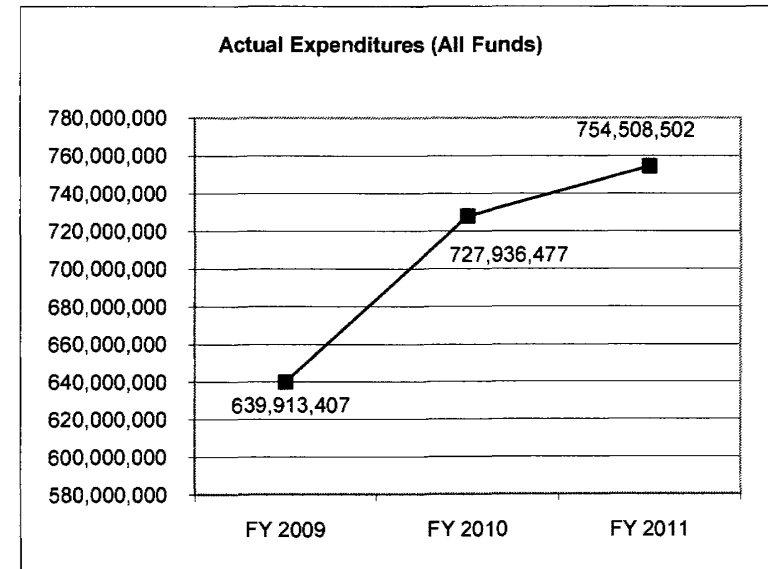
This core request is for ongoing funding to reimburse hospitals for services provided to fee-for-service MO HealthNet participants. Funding for this core is used to maintain hospital reimbursement at a sufficient level to ensure quality health care and provider participation. The FY 2012 budget authorizes payments to trauma centers contingent upon availability of the hospital provider tax as the state match. This core reflects a core reduction of \$50,000,000 (\$20,000,000 Federal Reimbursement Allowance Fund and \$30,000,000 Federal) for appropriations authorizing trauma center payments. These appropriations have not been used since FY 2008 since many trauma centers were unable to receive the payments under the criteria set forth in the Medicaid State Plan. MHD worked with the Centers for Medicaid and Medicare Services (CMS) to simplify the calculations and base payments on Medicaid utilization rather than trauma center criteria. This enables the department to maximize payments to hospitals under the new DSH audit rules while targeting those hospitals that serve a higher Medicaid population. Based on a FY 2011 estimate, approximately 131 hospitals will qualify based on Medicaid utilization. A corresponding new decision item is being requested in the Federal Reimbursement Allowance section.

## 3. PROGRAM LISTING (list programs included in this core funding)

Inpatient and Outpatient hospital services.

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	697,793,493	788,242,253	813,250,756	849,575,804
Less Reverted (All Funds)	(83,914)	(10,083,915)	(83,915)	N/A
Budget Authority (All Funds)	697,709,579	778,158,338	813,166,841	N/A
Actual Expenditures (All Funds)	639,913,407	727,936,477	754,508,502	N/A
Unexpended (All Funds)	57,796,172	50,221,861	58,658,339	N/A
Unexpended, by Fund:				
General Revenue	7,763,695	0	0	N/A
Federal	30,000,639	30,209,704	30,218,122	N/A
Other	20,031,838	20,012,157	28,440,217	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

- (1) Expenditures of \$6,130,109 were paid from the Supplemental Pool, expenditures totaling \$62,200,877 were paid from the Managed Care appropriation, expenditures totaling \$39,027,031 were paid from the FRA appropriation, and expenditures totaling \$39,424,181 were paid from the Pharmacy appropriation. FY 2009 lapse is for the FRA and federal share of trauma payments that DSS could not make (no earnings to support).
- (2) Expenditures of \$32,443,758 were paid from the Supplemental Pool. FY 2010 lapse is for the FRA and federal share of trauma payments that DSS could not make (no earnings to support).
- (3) Expenditures of \$21,899,227 were paid from the Supplemental Pool, expenditures totaling \$9,383,430 were paid from Pharmacy appropriation. FY 2011 lapse is for the FRA and federal share of trauma payments that DSS could not make (no earnings to support).

#### 4. FINANCIAL HISTORY

Cost Per Eligible - Per Member Per Month (PMPM)					
	Hospital PMPM*	Acute Care PMPM	Total PMPM	Hospital Percentage of Acute	Hospital Percentage of Total
PTD	\$404.68	\$953.39	\$1,579.47	42.45%	25.62%
Seniors	\$61.43	\$332.63	\$1,293.02	18.47%	4.75%
Custodial Parents	\$83.17	\$403.27	\$416.87	20.62%	19.95%
Children**	\$40.39	\$232.18	\$251.39	17.40%	16.07%
Pregnant Women	\$177.41	\$507.64	\$515.09	34.95%	34.44%

\* Claims only from FY 11 Table 23 Medical Statistics. Add-on payments funded from FRA provider tax not included.

\*\* CHIP eligibles not included

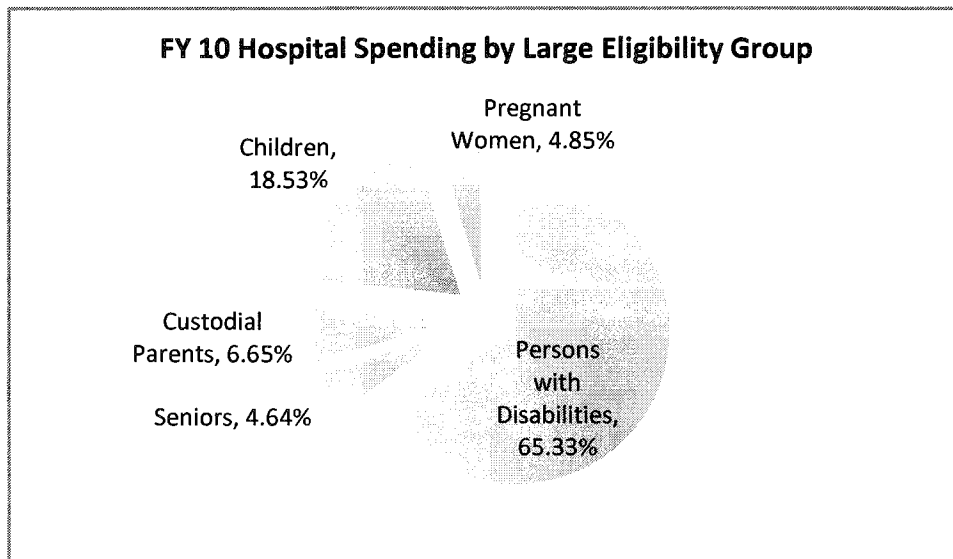
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PMPM by eligibility group and type of service serves as a baseline for management to determine if cost control interventions are working as intended. Monitoring PMPM amounts allow tracking by a population so that a shift in services is reflected in one metric.

The PMPM table reflects the PMPM amounts for hospital care, acute care, and total. The acute care PMPM is made up of payments for the following services: inpatient, physician/lab/x-ray, outpatient/clinic, drugs, managed care payments, Medicare co-pay/deductibles and other acute services administered by MHD. It does **not** include nursing facilities, in-home services, mental health services and state institutions. By comparing the hospital PMPM to the acute care PMPM, MHD management can monitor the progress of interventions controlled by MHD management.

The Spending by Large Eligibility Group (left) shows the percentage of spending by each eligibility group for hospitals. It provides a snapshot of what eligibility groups are receiving hospital services as well as the populations impacted by program changes.



Source: Table 23 Medical Statistics for FY 11.



**CORE RECONCILIATION DETAIL**

**DEPARTMENT OF SOCIAL SERVICES  
HOSPITAL CARE**

**5. CORE RECONCILIATION DETAIL**

				<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>										
				EE	0.00	0	215,000	215,000	430,000	
				PD	0.00	24,567,406	582,439,659	292,138,739	899,145,804	
				<b>Total</b>	<b>0.00</b>	<b>24,567,406</b>	<b>582,654,659</b>	<b>292,353,739</b>	<b>899,575,804</b>	
<b>DEPARTMENT CORE ADJUSTMENTS</b>										
Core Reduction	860	6743	PD	0.00	0	(30,000,000)		0	(30,000,000)	Eliminate appropriation authority for trauma center payments. Payments are not longer part of the State Plan and have not been made over the past couple of years. Upper Payment Limit (UPL) payments ar...
Core Reduction	860	6742	PD	0.00	0		0	(20,000,000)	(20,000,000)	Eliminate appropriation authority for trauma center payments. Payments are not longer part of the State Plan and have not been made over the past couple of years. Upper Payment Limit (UPL) payments ar...
<b>NET DEPARTMENT CHANGES</b>					<b>0.00</b>	<b>0</b>	<b>(30,000,000)</b>	<b>(20,000,000)</b>	<b>(50,000,000)</b>	
<b>DEPARTMENT CORE REQUEST</b>										
				EE	0.00	0	215,000	215,000	430,000	
				PD	0.00	24,567,406	552,439,659	272,138,739	849,145,804	
				<b>Total</b>	<b>0.00</b>	<b>24,567,406</b>	<b>552,654,659</b>	<b>272,353,739</b>	<b>849,575,804</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>										
				EE	0.00	0	215,000	215,000	430,000	
				PD	0.00	24,567,406	552,439,659	272,138,739	849,145,804	
				<b>Total</b>	<b>0.00</b>	<b>24,567,406</b>	<b>552,654,659</b>	<b>272,353,739</b>	<b>849,575,804</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
HOSPITAL CARE								
CORE								
PROFESSIONAL SERVICES	2,534,260	0.00	430,000	0.00	430,000	0.00	0	0.00
TOTAL - EE	2,534,260	0.00	430,000	0.00	430,000	0.00	0	0.00
PROGRAM DISTRIBUTIONS	751,974,242	0.00	899,145,804	0.00	849,145,804	0.00	0	0.00
TOTAL - PD	751,974,242	0.00	899,145,804	0.00	849,145,804	0.00	0	0.00
GRAND TOTAL	\$754,508,502	0.00	\$899,575,804	0.00	\$849,575,804	0.00	\$0	0.00
GENERAL REVENUE	\$15,249,439	0.00	\$24,567,406	0.00	\$24,567,406	0.00		0.00
FEDERAL FUNDS	\$482,994,370	0.00	\$582,654,659	0.00	\$552,654,659	0.00		0.00
OTHER FUNDS	\$256,264,693	0.00	\$292,353,739	0.00	\$272,353,739	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Hospital Care**

**Program is found in the following core budget(s): Hospital Care**

### 1. What does this program do?

*PROGRAM SYNOPSIS: This program provides payment for inpatient and outpatient hospital services for MO HealthNet fee-for-service participants.*

Hospital services, both inpatient and outpatient, are an essential part of a health care delivery system. These services are mandatory Medicaid covered services and are provided statewide. Hospital services have been part of the MO HealthNet program since November 1967. MO HealthNet inpatient hospital services are medical services provided in a hospital acute or psychiatric care setting for the care and treatment of MO HealthNet participants.

MO HealthNet outpatient hospital services include preventive, diagnostic, emergency, therapeutic, rehabilitative or palliative services provided in an outpatient setting. Examples of outpatient services are emergency room services, physical therapy, ambulatory surgery, or any service or procedure performed prior to admission.

Providers - To participate in the MO HealthNet fee-for-service program, hospitals must first meet certain requirements. Hospitals must be licensed and certified by the Missouri Department of Health and Senior Services for participation in the Title XVIII Medicare program. If the hospital is located out-of-state, the hospital must be licensed by that state's Department of Health or similar agency. If a state does not have a licensing agency, the hospital must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In addition, the hospital must complete a Title XIX Medicaid Participation Agreement/Questionnaire, and a MO HealthNet enrollment application. The application of enrollment must be approved by the Department of Social Services, MO HealthNet Division.

MO HealthNet Reimbursement - Reimbursement for inpatient hospital stays is determined by a prospective reimbursement plan implemented in FY 82. The plan provides for an inpatient hospital reimbursement rate based on the 1995 cost report to reimburse for inpatient stays in accordance with a specified admission diagnosis.

When a per diem reimbursement rate is established for each hospital, MO HealthNet pays the lesser of: 1) the number of days assigned by the utilization review agent; 2) the number of days billed as covered services; or 3) the Professional Activity Study (PAS) limitation for any diagnosis not subject to review by the utilization review agent.

A hospital is eligible for a special per diem rate increase if it meets prescribed requirements concerning new inpatient health services or new hospital construction.

Outpatient services, excluding certain diagnostic laboratory procedures, are paid on a prospective outpatient reimbursement methodology. The prospective outpatient payment percentage is calculated using the MO HealthNet overall outpatient cost-to-charge ratio from the fourth, fifth and sixth prior base year cost reports regressed to the current state fiscal year. The prospective outpatient payment percentage cannot exceed 100% and cannot be less than 20%. New MO HealthNet providers that do not have fourth, fifth and sixth prior year cost reports will be set at 75% for the first three fiscal years in which the hospital operates and will have a cost settlement calculated for these years. A prospective outpatient rate will then be calculated and used for the fourth and subsequent years of operation. The weighted average prospective outpatient rate is 29% for FY 12.

Effective for payment dates beginning October 1, 2011, and annually updated, the technical component of outpatient radiology procedures will be reimbursed from a Medicaid fee schedule. Fee schedule amounts will be based on a percentage of Medicare's fee schedule.

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Other Reimbursement to Hospitals - Hospitals may also receive reimbursement using funding from the Federal Reimbursement Allowance (FRA) program. The FRA program is a funding source for inpatient and outpatient services. It is also a funding source for MO HealthNet Managed Care, the Women's Health Services, and CHIP programs. These programs provide payments for the cost of providing care to MO HealthNet participants and the uninsured.

Under the FRA program, hospitals pay a federal reimbursement allowance (i.e. provider tax) for the privilege of doing business in the state. The assessment is a percentage levied against both net hospital inpatient revenue and net hospital outpatient revenue. For the first quarter of FY 12, the assessment rate is 5.45% and the department has filed a proposed regulation to increase the assessment to 5.95% for the remaining three quarters, provided the federal maximum allowable assessment rate increases to 6% as anticipated. The net inpatient and net outpatient revenues are determined from the hospitals' Medicare/Medicaid cost reports that are filed annually with the MO HealthNet Division. The MO HealthNet Division uses funds generated from the FRA program as the equivalent of General Revenue funds. The funds are distributed to the hospitals through a combination of payments.

The payments include funding for: inpatient per diem payments, outpatient payments, and add-on payments such as direct Medicaid payments, uninsured (DSH), and utilization add-on payments (only applies to Safety Net hospitals and Children's Hospitals).

The method of reimbursing hospitals for the add-on payments is different depending on if they are a safety net hospital or a disproportionate share hospital (DSH). The DSH hospitals are classified as either first tier, second tier, or other DSH depending on the result of an analysis of annual hospital cost reports.

**DSH Criteria:**

1. If the facility offered nonemergency obstetric services as of December 31, 1987, there must be at least 2 obstetricians with staff privileges who have agreed to provide obstetric services to MO HealthNet participants. Rural hospitals, as defined by the federal Executive Office of Management and Budget, may qualify any physician with staff privileges as an obstetrician. This section does not apply to hospitals either with inpatients predominantly under 18 years of age or which did not offer nonemergency obstetric services as of December 31, 1987; and
2. The hospital meets one of the following:
  - a. The MO HealthNet inpatient utilization rate is at least one standard deviation above the state's mean MO HealthNet inpatient utilization rate for all Missouri hospitals; or
  - b. The utilization of services by low-income clients is greater than 25% of their total utilization.
3. The hospital meets one of the following:
  - a. The unsponsored care ratio is at least 10%; or
  - b. The hospital is ranked in the top 15 hospitals based on MO HealthNet patient days and their MO HealthNet nursery and neonatal utilization is greater than 35% of the hospital's total nursery and neonatal utilization; or
  - c. At least 9% of the hospital's MO HealthNet days are provided in the hospital's neonatal unit.
4. The hospital annually provides more than 5,000 Title XIX days of care and the Title XIX nursery days represent more than 50% of the hospital's total nursery days.
5. The hospital does not meet the requirements set forth in paragraphs 1 - 4 above, but has a Medicaid inpatient utilization percentage of at least 1% for Medicaid eligible participants.

A hospital's DSH designation depends on which of the above criteria it meets:

1. 1st Tier DSH -- The hospital meets the criteria in paragraphs 1 and 3;
2. 2nd Tier DSH -- The hospital meets the criteria in paragraphs 1 and 2 or paragraphs 1 and 4;
3. Other DSH -- The hospital meets the criteria in paragraph 5.

A hospital can qualify as a safety net hospital if:

1. It meets the criteria set forth above in paragraphs 1 and 2 above; and,
2. It meets one of the following criteria:
  - a. The unsponsored care (charity care) ratio is at least 65% and is licensed for less than 50 inpatient beds; or
  - b. The unsponsored care ratio is at least 65% and is licensed for 50 inpatient beds or more and has an occupancy rate of more than 40%; or
  - c. It is operated by the Board of Curators as defined in chapter 172 RSMo; or
  - d. It is operated by the Department of Mental Health.

For a more detailed description of the FRA program see the FRA narrative.

Trends - Elderly persons and persons with disabilities are the highest users of health care services and costliest population per capita. These two populations represent 25% of all Medicaid eligibles and represent 64% of all expenditures. Persons with disabilities are the primary users of hospital services. This group accounts for 45% of fee-for-service hospital users and 60% of fee-for-service hospital expenditures. The elderly are 11% of fee-for-service hospital users and 5% of fee-for-service hospital expenditures.

Pre-certification of inpatient hospital stays for patients under the age of 21 admitted to psychiatric units or facilities and the certificate of need process are measures used to control costs. The pre-certification reviews are done by a utilization review agent. Admission and continued stay reviews are performed on a pre-approved basis for all fee-for-service MO HealthNet participants admitted to acute care hospitals except for certain pregnancy, delivery and newborn diagnoses, and for participants who are eligible for both Medicare and MO HealthNet. The reviews are done to ensure that hospital admission and each day of inpatient care are medically necessary. The review may be performed prior to admission, post admission or retrospectively. An initial length of stay (LOS) is assigned by a nurse or physician reviewer.

In July 2010, the MO HealthNet Division, in conjunction with Affiliated Computer Services (ACS) and MedSolutions (MSI), implemented a new quality-based Radiology Benefit Management Program (RBM). The RBM is an expansion of the existing pre-certification process currently being used for MRIs and CTs of the brain, head, chest and spine. The RBM works to determine clinical appropriateness of the usage of high-tech radiology services and cardiac imaging and provides guidelines for application and use based on expert information and evidence-based data. Pre-certification requests are handled using robust clinical guidelines. These guidelines are used to ensure the appropriate scope, complexity and clinical need of the tests that will be performed.

**2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State statute: RSMo. 208.152, 208.153; Federal law: Social Security Act Sections 1905(a)(1) and (2), 1923(a)-(f);

Federal regulations: 42 CFR 440.10 and 440.20

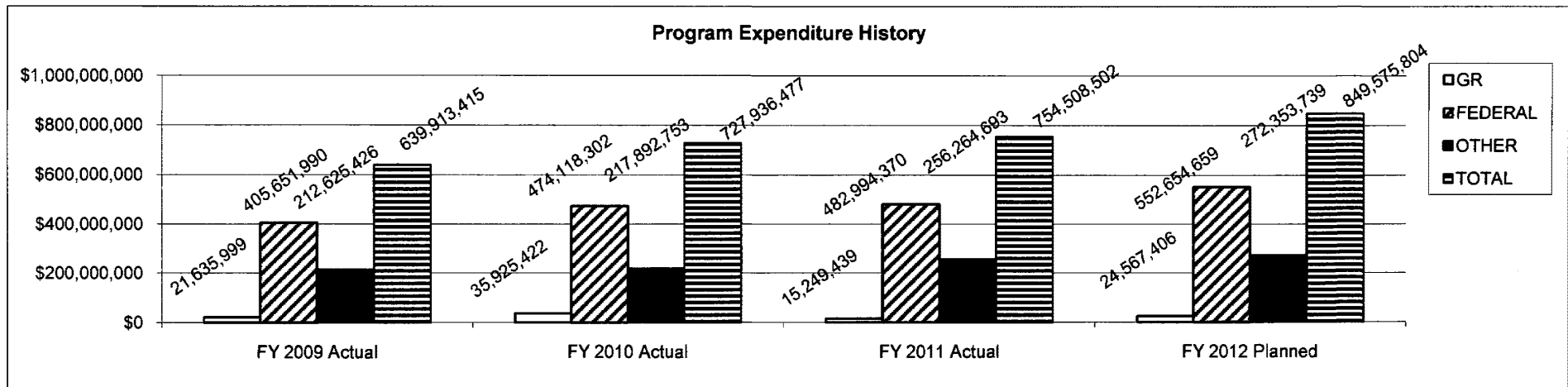
**3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures made in accordance with the approved State Plan. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 is a blended 63.41% federal match. The state matching requirement is 36.59%.

**4. Is this a federally mandated program? If yes, please explain.**

Yes, if the state elects to have a Medicaid program.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**

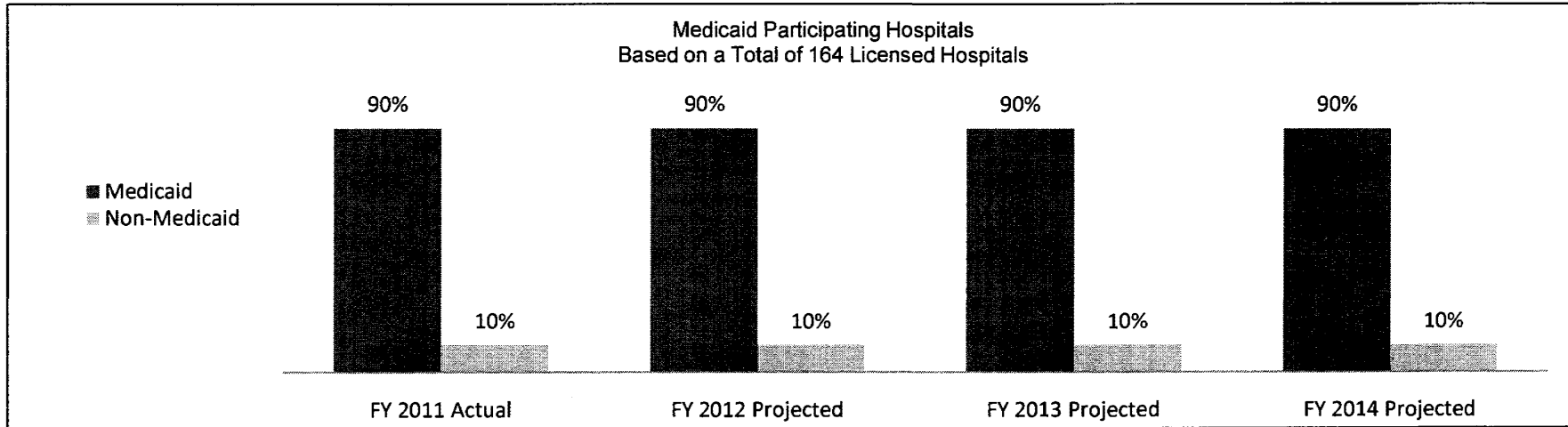


**6. What are the sources of the "Other " funds?**

Uncompensated Care Fund (0108), Federal Reimbursement Allowance Fund (0142), Health Initiatives Fund (0275), Third Party Liability Collections Fund (0120), and Healthy Families Trust Fund (0625).

**7a. Provide an effectiveness measure.**

Effectiveness Measure 1: Provide reimbursement that is sufficient to ensure hospitals enroll in the MO HealthNet program. In SFY 2011, at least 90% of licensed hospitals in the state participated in the Mo HealthNet program.

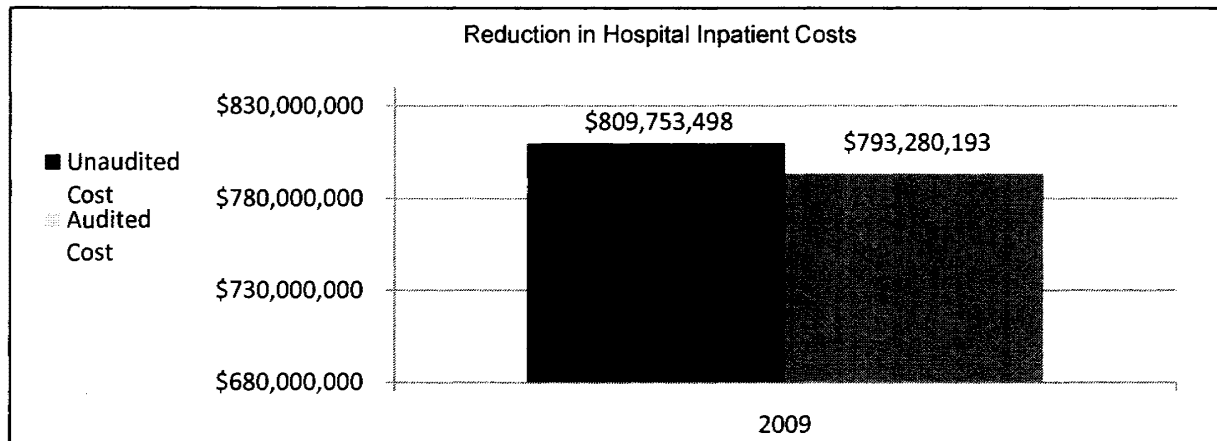


Effectiveness Measure 2: Inpatient and outpatient services are available to all fee-for-service MO HealthNet participants. In those regions of the state where Managed Care has been implemented participants have hospital services available through the Managed Care health plans. In SFY 2011, there were 699,000 inpatient days and 12,143,000 outpatient services provided through the hospital program.

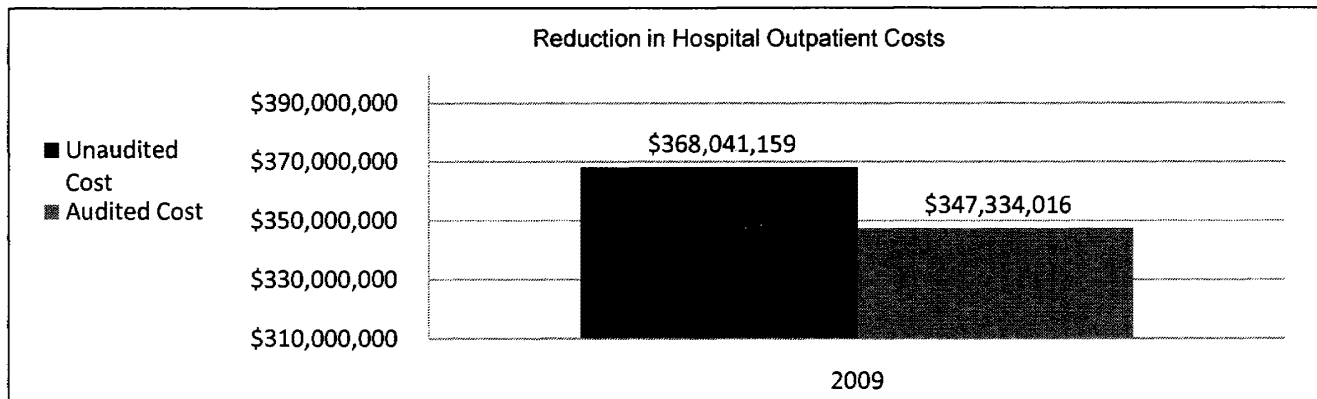
SFY	No. of Inpatient Days		No. of Outpatient Services (Thousands)	
	Actual	Projected	Actual	Projected
2009	571,207		8,842.0	
2010	626,540		11,723.9	
2011	699,000		12,143.0	
2012		773,304		12,568.0
2013		855,506		13,008.0
2014		964,446		13,463.2

**7b. Provide an efficiency measure.**

Efficiency Measure 1: Ensure hospital inpatient Medicaid costs included in determining MO HealthNet inpatient reimbursement rates are allowable by performing audits of the provider's cost reports. During the 2009 fiscal year cost report audits, over \$16 million of hospital costs were disallowed as a result of MHD audits.

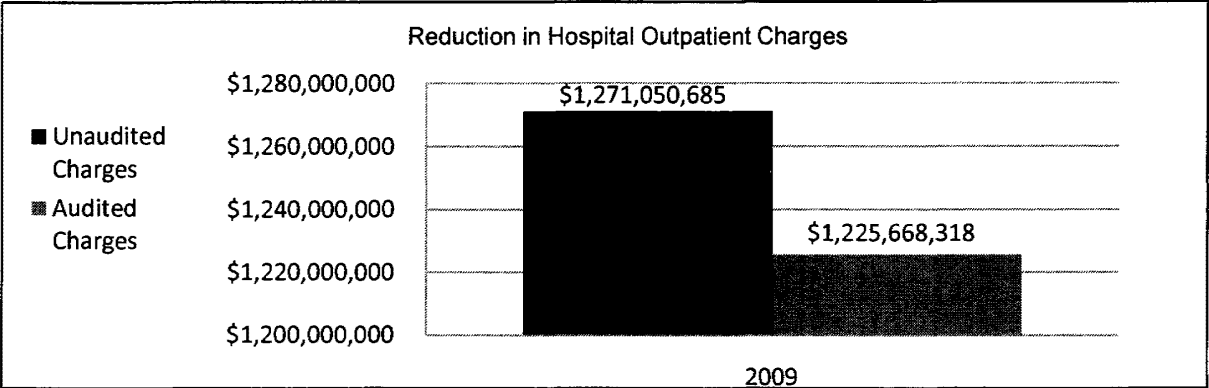


Efficiency Measure 2: Ensure hospital outpatient Medicaid costs included in determining MO HealthNet outpatient reimbursement rates are allowable by performing audits of the provider's cost reports. During the 2009 fiscal year audits, over \$20 million of hospital costs were disallowed as a result of MHD audits.

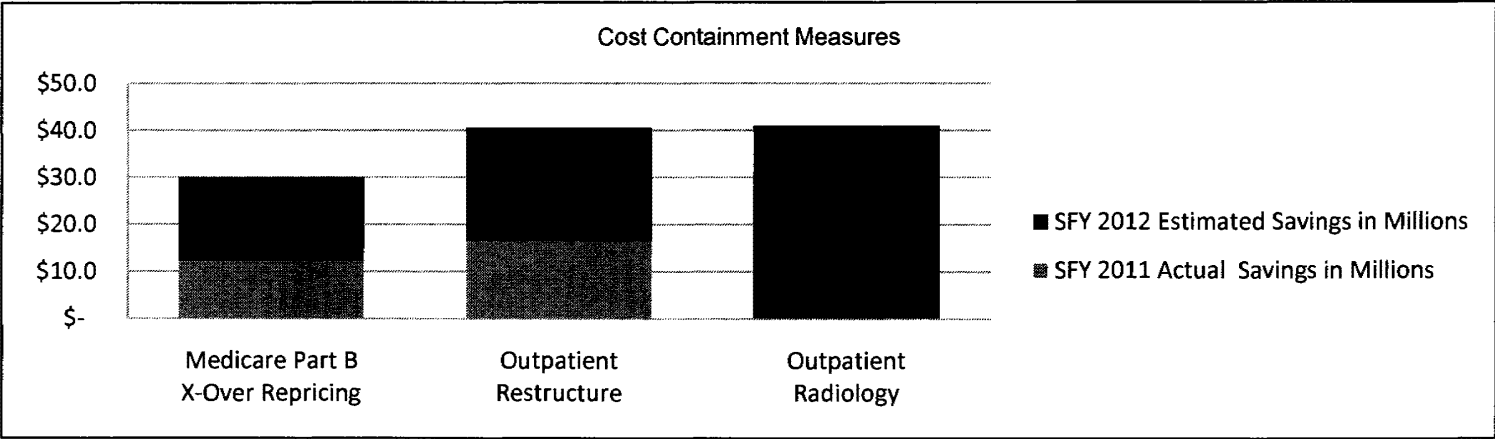




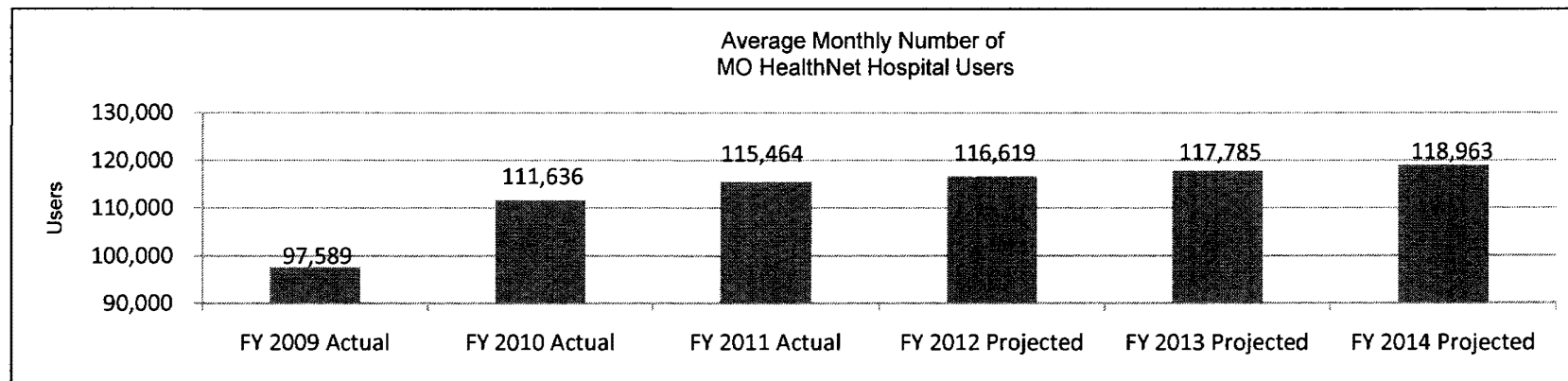
Efficiency Measure 3: Ensure hospital outpatient Medicaid charges included in determining MO HealthNet outpatient reimbursement rates are allowable by performing audits of the provider's cost reports. During the 2009 fiscal year audits, over \$45 million of hospital charges were disallowed as a result of MHD audits.



Efficiency Measure 4: The MO HealthNet program implemented cost containment measures in SFY 2011 to reduce the amount that is being paid to hospitals for Medicare Part B Cross-over claims and for Medicaid Outpatient claims. In SFY 2012, the MO HealthNet program plans to pay outpatient radiology claims based on a fee schedule instead of the outpatient percentage . Total savings for SFY 2011 was \$28.8 million. Total estimated savings for SFY 2012 is \$82.7 million.



**7c. Provide the number of clients/individuals served, if applicable.**



**7d. Provide a customer satisfaction measure, if available.**

# **Physician Payments for Safety Net**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PHYSICIAN PAYMENTS SAFETY NET								
CORE								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	4,638,523	0.00	8,000,000	0.00	8,000,000	0.00	0	0.00
TOTAL - PD	4,638,523	0.00	8,000,000	0.00	8,000,000	0.00	0	0.00
TOTAL	4,638,523	0.00	8,000,000	0.00	8,000,000	0.00	0	0.00
GRAND TOTAL	\$4,638,523	0.00	\$8,000,000	0.00	\$8,000,000	0.00	\$0	0.00

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Physician Payments for Safety Net

Budget Unit: 90558C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD		8,000,000		8,000,000
TRF				
Total		8,000,000		8,000,000
FTE			0.00	

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

Note: An "E" is requested for the \$8,000,000 in Federal Fund authority.

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

## 2. CORE DESCRIPTION

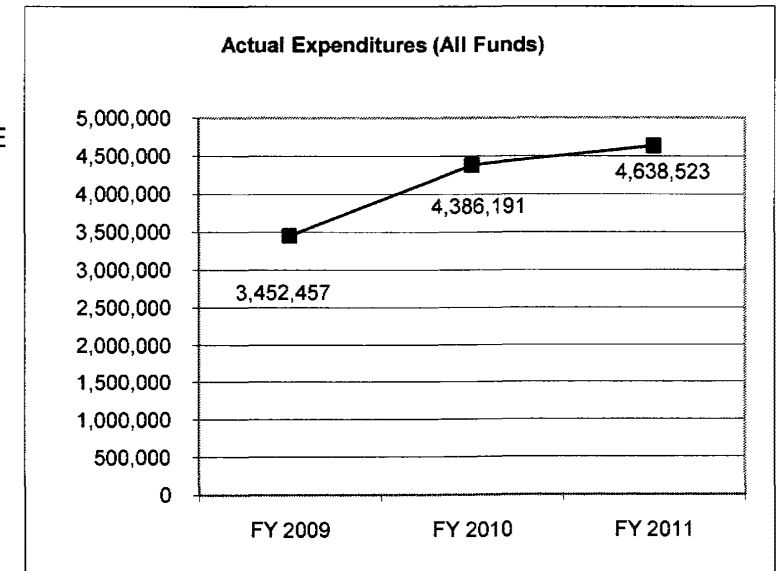
Safety Net hospitals are critical providers of care to the Medicaid and uninsured populations and must be able to attract and maintain a sufficient supply of qualified physicians in order to provide quality services. This core provides funding for enhanced payments to Truman Medical Center Physicians and University of Missouri-Kansas City Physicians.

## 3. PROGRAM LISTING (list programs included in this core funding)

Physician Payments for Safety Net

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	8,000,000	8,000,000	8,000,000	8,000,000 E
Less Reverted (All Funds)				N/A
Budget Authority (All Funds)	8,000,000	8,000,000	8,000,000	N/A
Actual Expenditures (All Funds)	3,452,457	4,386,191	4,638,523	N/A
Unexpended (All Funds)	4,547,543	3,613,809	3,361,477	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	4,547,543	3,613,809	3,361,477	N/A
Other	0	0	0	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

Estimated "E" appropriations for Federal fund.

(1) Lapse of \$4,547,543 in excess federal authority.

(2) Lapse of \$3,613,809 in excess federal authority.

(3) Lapse of \$3,361,477 in excess federal authority.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES**

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**PHYSICIAN PAYMENTS SAFETY NET**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	0	8,000,000	0	8,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>8,000,000</b>	<b>0</b>	<b>8,000,000</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	0	8,000,000	0	8,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>8,000,000</b>	<b>0</b>	<b>8,000,000</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	0	8,000,000	0	8,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>8,000,000</b>	<b>0</b>	<b>8,000,000</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
PHYSICIAN PAYMENTS SAFETY NET								
CORE								
PROGRAM DISTRIBUTIONS	4,638,523	0.00	8,000,000	0.00	8,000,000	0.00	0	0.00
TOTAL - PD	4,638,523	0.00	8,000,000	0.00	8,000,000	0.00	0	0.00
GRAND TOTAL	\$4,638,523	0.00	\$8,000,000	0.00	\$8,000,000	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$4,638,523	0.00	\$8,000,000	0.00	\$8,000,000	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00



## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Physician Payments for Safety Net**

**Program is found in the following core budget(s): Physician Payments for Safety Net**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides enhanced physician reimbursement payments for services provided to MO HealthNet participants by hospitals designated as safety net hospitals. Safety net hospitals traditionally see a high volume of Medicaid and uninsured patients. This program was established to provide a funding mechanism to enhance payments to these hospitals.*

Safety Net hospitals are critical providers of care to the Medicaid and uninsured populations and must be able to attract and maintain a sufficient supply of qualified physicians in order to provide quality services. Enhanced payments are made to Truman Medical Center Physicians and University of Missouri-Kansas City Physicians. Appropriated funding is based on the following projections:

Enhanced Payment for Truman Medical Center Physicians	\$3,000,000
Enhanced Payment for University of Missouri-Kansas City Physicians	\$5,000,000

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, 208.153; Federal law: Social Security Act Sections 1905(a)(1) and (2), 1923(a)-(f);

Federal regulations: 42 CFR 440.10 and 440.20

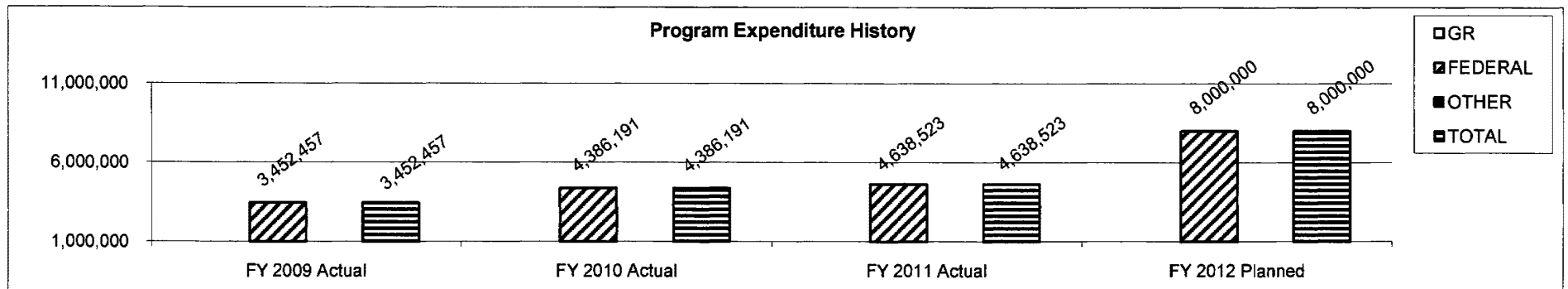
### 3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 is a blended 63.41% federal match. The state matching requirement is 36.59%. For those public entities identified above who use state and local general revenue to provide eligible services to MO HealthNet participants, the MO HealthNet Division provides payment of the federal share for these eligible services.

### 4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other " funds?

N/A

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

7d. Provide a customer satisfaction measure, if available.

# **FQHC Distribution**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
FQHC DISTRIBUTION								
CORE								
PROGRAM-SPECIFIC								
GENERAL REVENUE	6,786,000	0.00	4,020,000	0.00	4,020,000	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	9,000,000	0.00	9,000,000	0.00	0	0.00
TOTAL - PD	6,786,000	0.00	13,020,000	0.00	13,020,000	0.00	0	0.00
TOTAL	6,786,000	0.00	13,020,000	0.00	13,020,000	0.00	0	0.00
GRAND TOTAL	\$6,786,000	0.00	\$13,020,000	0.00	\$13,020,000	0.00	\$0	0.00

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# CORE DECISION ITEM

Department: Social Services  
 Division: MO HealthNet  
 Core: Federally Qualified Health Centers (FQHC) Distribution

Budget Unit: 90559C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	4,020,000	9,000,000		13,020,000
TRF				
Total	4,020,000	9,000,000		13,020,000
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

Note: An "E" is requested for the \$9,000,000 Federal Fund authority.

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

## 2. CORE DESCRIPTION

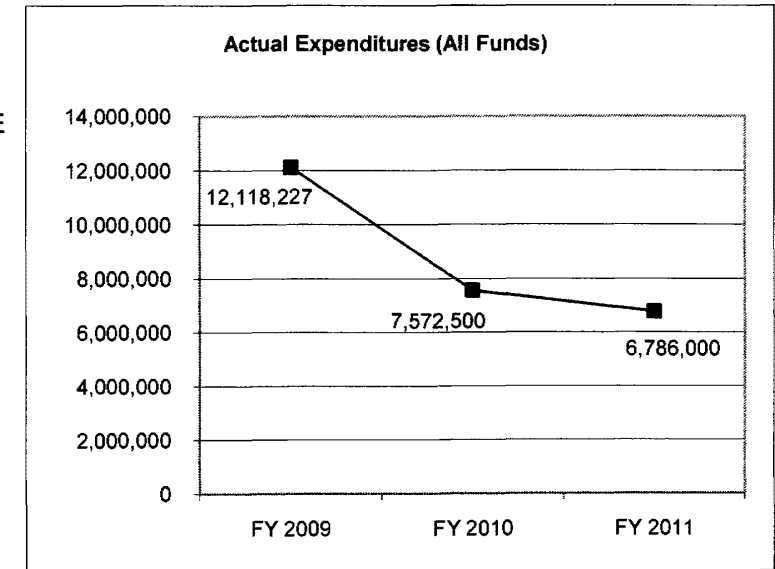
This core request is to allow Federally Qualified Health Centers (FQHCs) to provide more services in their facilities and improve access to health care for the uninsured and under-insured. Funding for this core is for equipment and infrastructure in the FQHC and to cover the expense of providing health care services in the FQHC setting. In addition, the core request is for funding payments for Health Home sites.

## 3. PROGRAM LISTING (list programs included in this core funding)

Federally Qualified Health Centers (FQHC)

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.	
Appropriation (All Funds)	14,350,000	9,250,000	7,800,000	13,020,000	E
Less Reverted (All Funds)	(2,231,273)	(1,677,500)	(1,014,000)	N/A	
Budget Authority (All Funds)	12,118,727	7,572,500	6,786,000	N/A	
Actual Expenditures (All Funds)	12,118,227	7,572,500	6,786,000	N/A	
Unexpended (All Funds)	500	0	0	N/A	
Unexpended, by Fund:					
General Revenue	500	0	0	N/A	
Federal	0	0	0	N/A	
Other	0	0	0	N/A	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

**Notes:**

Estimated "E" appropriations for Federal fund.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES****FQHC DISTRIBUTION**

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**5. CORE RECONCILIATION DETAIL**

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	Budget Class	FTE	GR	Federal	Other	Total	Explanation
<b>TAFP AFTER VETOES</b>							
	PD	0.00	4,020,000	9,000,000	0	13,020,000	
	<b>Total</b>	<b>0.00</b>	<b>4,020,000</b>	<b>9,000,000</b>	<b>0</b>	<b>13,020,000</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	4,020,000	9,000,000	0	13,020,000	
	<b>Total</b>	<b>0.00</b>	<b>4,020,000</b>	<b>9,000,000</b>	<b>0</b>	<b>13,020,000</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	4,020,000	9,000,000	0	13,020,000	
	<b>Total</b>	<b>0.00</b>	<b>4,020,000</b>	<b>9,000,000</b>	<b>0</b>	<b>13,020,000</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
FQHC DISTRIBUTION								
CORE								
PROGRAM DISTRIBUTIONS	6,786,000	0.00	13,020,000	0.00	13,020,000	0.00	0	0.00
TOTAL - PD	6,786,000	0.00	13,020,000	0.00	13,020,000	0.00	0	0.00
GRAND TOTAL	\$6,786,000	0.00	\$13,020,000	0.00	\$13,020,000	0.00	\$0	0.00
GENERAL REVENUE	\$6,786,000	0.00	\$4,020,000	0.00	\$4,020,000	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$9,000,000	0.00	\$9,000,000	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00



## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Federally Qualified Health Centers (FQHC) Distribution**

**Program is found in the following core budget(s): Federally Qualified Health Centers (FQHC) Distribution**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Allows Federally Qualified Health Centers to provide more services in their facilities and improve access to health care for the uninsured and under-insured. Grant funds are used for capital expansion, infrastructure redesigning, and primary health and dental care for the uninsured.*

FQHCs are community health centers that provide comprehensive primary care to low-income and medically under-served urban and rural communities. Because of an inadequate number of providers, Missourians have found it difficult to find health care providers and are subject to lengthy postponements in receiving health care services. In rural areas, these issues are more pronounced as people must frequently travel to larger cities in order to receive necessary care. By equipping the FQHCs with infrastructure and personnel, the under-served population will have increased access to health care, especially in medically under-served areas.

Examples of how these grants help expand access to health care services for the low-income and uninsured include: 1) Supporting nontraditional hours of operation (weekend and special evening hours). FQHCs recognize that many Missourians do not have the luxury of accessing care during normal business hours. 2) Defraying the costs of caring for the uninsured. FQHCs are required to accept uninsured patients as they do insured patients. 3) Funding staff and infrastructure to provide services not usually accessible to FQHC patients such as dental services.

The Department of Social Services contracts with the Missouri Primary Care Association to act as a fiscal intermediary for the distribution of the FQHC grants, assuring accurate and timely payments to the subcontractors; and, as a central data collection point for evaluating program impact and outcomes. The Missouri Primary Care Association is recognized as Missouri's single primary care association by the Federal Health Resource Service Administration. The goals of the nation's Primary Care Associations are to partner in the development, maintenance and improvement of access to health care services, reducing disparities in health status between majority and minority populations.

The MO HealthNet Division of the Department of Social Services is implementing a Health Home provider program in accordance with Section 2703 of the Affordable Care Act of 2010. Health Home sites will receive per-member-per-month (PMPM) payments for the additional services they will be required to perform. Most of the primary care sites that will be selected to participate in the Health Home program will be FQHC sites. The funding for the current FQHC distribution contract will be used as the state share for MO HealthNet primary care Health Home payments. These payments will start in late SFY 2012.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.153, 208.201, 660.026; Federal law: Social Security Act Section 1905(a)(2); Federal regulation: 42 CFR 440.210

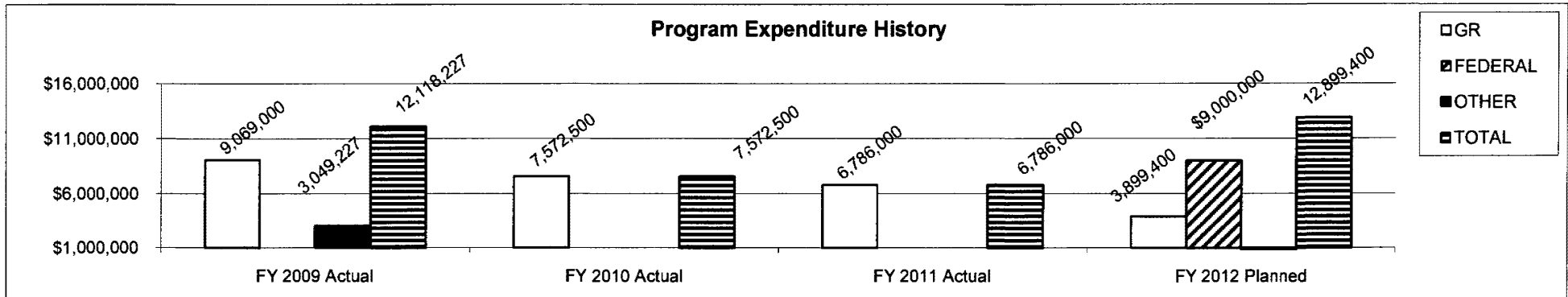
### 3. Are there federal matching requirements? If yes, please explain.

The Health Homes are funded at a 90% federal match. FQHC distributions are funded with 100% General Revenue.

**4. Is this a federally mandated program? If yes, please explain.**

No.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



Reverted: \$120,600 GR Fund.

**6. What are the sources of the "Other " funds?**

Health Care Technology Fund (0170) in FY09.

**7a. Provide an effectiveness measure.**

Effectiveness Measure: State grants funded with this appropriation assist in leveraging funds from the Federal Bureau of Primary Health Care. The total amount of funds leveraged in calendar year 2010 was \$44,606,943.

Total Funds Leveraged for Missouri FQHCs	
Calendar Year	Total Economic Impact
2007	\$38,947,659
2008	\$42,168,226
2009	\$42,715,258
2010	\$44,606,943

Source: Bureau of Primary Health Care, [bphc.hrsa.gov](http://bphc.hrsa.gov)

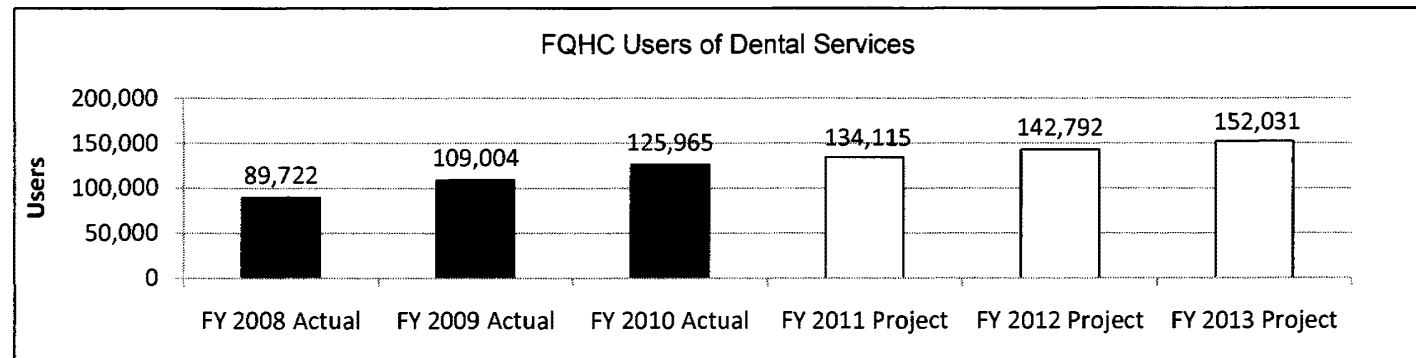
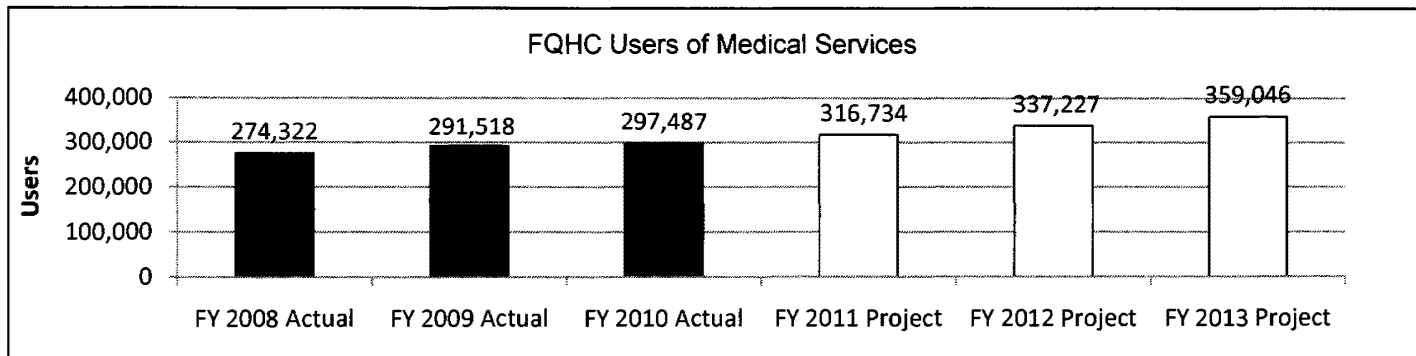
**7b. Provide an efficiency measure.**

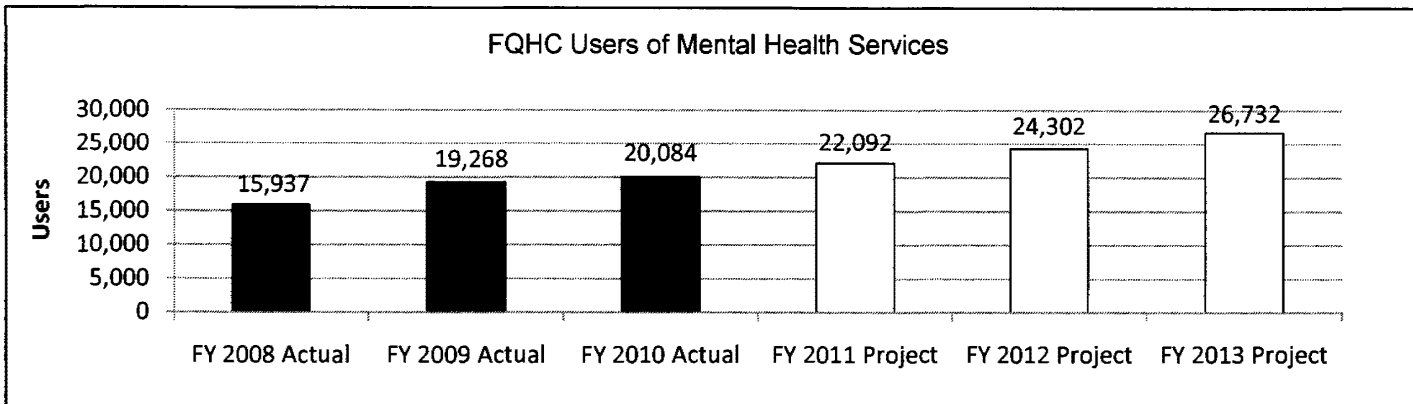
Efficiency Measure: FQHCs provide primary health care for the uninsured in their local communities. Missouri FQHCs provided primary health care to uninsured individuals in their local communities at a cost of \$628 per user in calendar year 2010.

Cost per User	
Calendar Year	Cost
2006	\$521
2007	\$535
2008	\$562
2009	\$602
2010	\$628

Source: Bureau of Primary Health Care, [bphc.hrsa.gov](http://bphc.hrsa.gov)

**7c. Provide the number of clients/individuals served, if applicable.**





**7d. Provide a customer satisfaction measure, if available.**

**IGT Health Care Home**

# FY13 Department of Social Services Report #9

# DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
IGT HEALTH CARE HOME								
CORE								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	9,000,000	0.00	9,000,000	0.00	0	0.00
INTERGOVERNMENTAL TRANSFER	0	0.00	1,000,000	0.00	1,000,000	0.00	0	0.00
TOTAL - PD	0	0.00	10,000,000	0.00	10,000,000	0.00	0	0.00
TOTAL	0	0.00	10,000,000	0.00	10,000,000	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$10,000,000	0.00	\$10,000,000	0.00	\$0	0.00

# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: IGT Health Care Home

Budget Unit: 90574C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD		9,000,000	1,000,000	10,000,000
TRF				
Total		9,000,000	1,000,000	10,000,000

FTE 0.00

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Intergovernmental Transfers (0139)

Note: An "E" is requested for \$1,000,000 Intergovernmental Transfers and \$9,000,000 Federal Funds.

FY 2013 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD				
TRF				
Total				

FTE

Est. Fringe	0	0	0	0
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Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

## 2. CORE DESCRIPTION

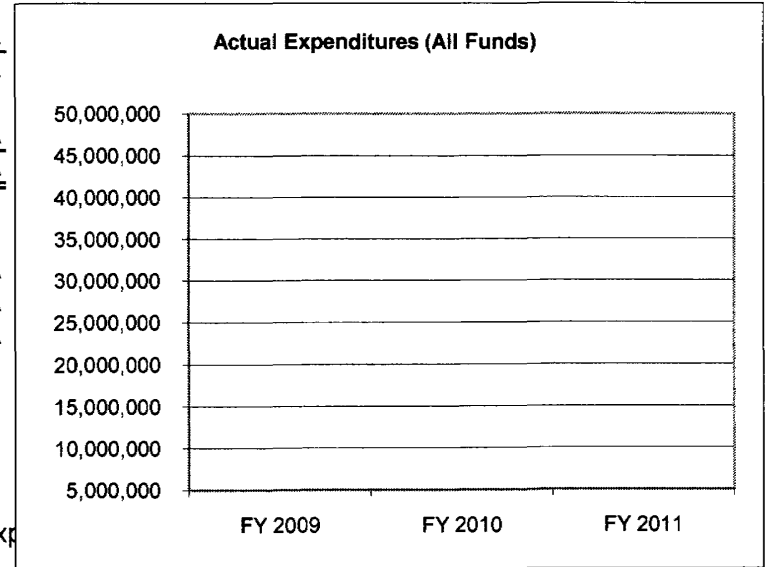
The core request is for funding payments for MO HealthNet participants through intergovernmental transfers for health home sites affiliated with public entities. Health home sites will receive per-member-per-month (PMPM) payments for the additional services they will be required to perform.

## 3. PROGRAM LISTING (list programs included in this core funding)

IGT Health Home

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)				10,000,000
Less Reverted (All Funds)				N/A
Budget Authority (All Funds)	0	0	0	N/A
Actual Expenditures (All Funds)				N/A
Unexpended (All Funds)	0	0	0	N/A
Unexpended, by Fund:				
General Revenue				N/A
Federal				N/A
Other				N/A



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary exp

#### NOTES:

Program starts in FY2012.



**CORE RECONCILIATION DETAIL**

**DEPARTMENT OF SOCIAL SERVICES**

**IGT HEALTH CARE HOME**

**5. CORE RECONCILIATION DETAIL**

	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	0	9,000,000	1,000,000	10,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>9,000,000</b>	<b>1,000,000</b>	<b>10,000,000</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	0	9,000,000	1,000,000	10,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>9,000,000</b>	<b>1,000,000</b>	<b>10,000,000</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	0	9,000,000	1,000,000	10,000,000	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>9,000,000</b>	<b>1,000,000</b>	<b>10,000,000</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
IGT HEALTH CARE HOME								
CORE								
PROGRAM DISTRIBUTIONS	0	0.00	10,000,000	0.00	10,000,000	0.00	0	0.00
TOTAL - PD	0	0.00	10,000,000	0.00	10,000,000	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$10,000,000	0.00	\$10,000,000	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$9,000,000	0.00	\$9,000,000	0.00		0.00
OTHER FUNDS	\$0	0.00	\$1,000,000	0.00	\$1,000,000	0.00		0.00

## PROGRAM DESCRIPTION

**Department:** Social Services

**Program Name:** IGT Health Care Home

**Program is found in the following core budget(s):** IGT Health Care Home

### 1. What does this program do?

*PROGRAM SYNOPSIS: MO HealthNet will pay providers to coordinate care through a "health home" for individuals with chronic conditions.*

Federal law gives MO HealthNet the option to pay providers to coordinate care through a "Health Home" for individuals with chronic conditions. A health home is a "designated provider" or a health team that provides health home services to an individual with a chronic condition. A "designated provider" can be a physician, clinical practice or clinical group practice, rural clinic, community health center, home health agency, or any other entity or provider that is determined by MO HealthNet and approved by the Secretary of Health and Human Services to be a qualified health home. A team of health care professionals acting as a health home may include physicians and other professionals such as a nurse care coordinator, nutritionist or social worker. Health homes may be freestanding, virtual, or based at a hospital or other facility. Health home services include comprehensive care management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings, patient and family support, and referral to community and social support services. Health homes are required to use "health information technology" to link services. Individuals who are eligible for health home services must have at least two chronic conditions or one chronic condition and the risk of having a second.

Pending CMS approval, DSS will make payment for start-up costs and lost productivity due to collaboration demands on staff not covered by other streams of payment. In addition, clinical care management per member per month (PMPM) payments will be made for the reimbursement of the cost of staff primarily responsible for delivery of services not covered by other reimbursement (Primary Care Nurses) whose duties are not otherwise reimbursable by MO HealthNet. Also, DSS will make payment to practices for 50% of the value of the reduction in total health care PMPM cost, including the payments mentioned above, for the practice site's attributed MO HealthNet patients, relative to prior year experience.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

Federal law: ACA Section 2703; Section 1945 of Title XIX of the Social Security Act.

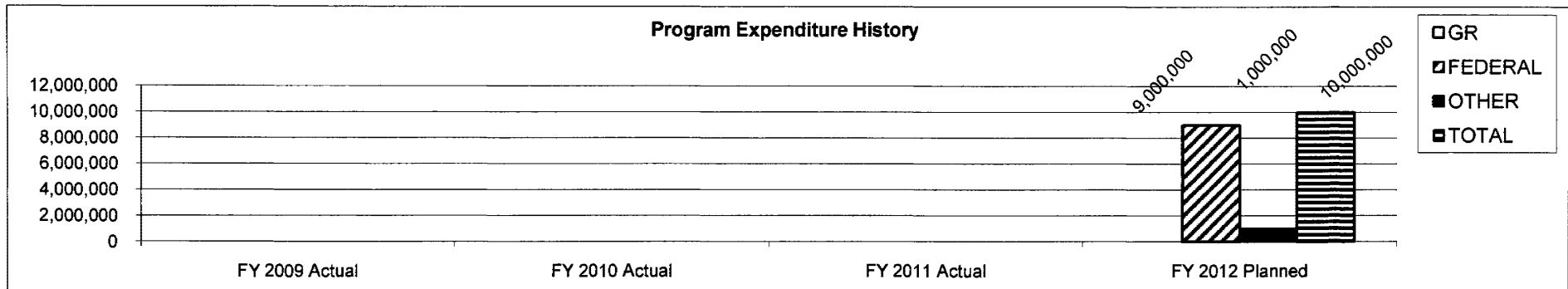
### 3. Are there federal matching requirements? If yes, please explain.

Expenditures are matched at 90% federal funds.

### 4. Is this a federally mandated program? If yes, please explain.

No.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



**6. What are the sources of the "Other " funds?**

Department of Social Services Intergovernmental Transfer Fund.

**7a. Provide an effectiveness measure.**

**7b. Provide an efficiency measure.**

**7c. Provide the number of clients/individuals served, if applicable.**

**7d. Provide a customer satisfaction measure, if available.**

# **Federal Reimbursement Allowance**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
FED REIMB ALLOWANCE								
CORE								
EXPENSE & EQUIPMENT								
FEDERAL REIMBURSMENT ALLOWANCE	1,000,500	0.00	0	0.00	0	0.00	0	0.00
TOTAL - EE	1,000,500	0.00	0	0.00	0	0.00	0	0.00
PROGRAM-SPECIFIC								
FEDERAL REIMBURSMENT ALLOWANCE	916,043,762	0.00	878,929,394	0.00	878,929,394	0.00	0	0.00
TOTAL - PD	916,043,762	0.00	878,929,394	0.00	878,929,394	0.00	0	0.00
TOTAL	917,044,262	0.00	878,929,394	0.00	878,929,394	0.00	0	0.00
FRA Increase Authority - 1886021								
PROGRAM-SPECIFIC								
FEDERAL REIMBURSMENT ALLOWANCE	0	0.00	0	0.00	67,500,000	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	67,500,000	0.00	0	0.00
TOTAL	0	0.00	0	0.00	67,500,000	0.00	0	0.00
GRAND TOTAL	\$917,044,262	0.00	\$878,929,394	0.00	\$946,429,394	0.00	\$0	0.00

# CORE DECISION ITEM

Department: Social Services  
 Division: MO HealthNet  
 Core: Federal Reimbursement Allowance (FRA)

Budget Unit: 90553C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD			878,929,394	878,929,394
TRF				
Total			878,929,394	878,929,394
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)

Note: An "E" is requested for the \$878,929,394 Federal Reimbursement Allowance Fund.

FY 2013 Governor's Recommendation				
	GR	Fed	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

## 2. CORE DESCRIPTION

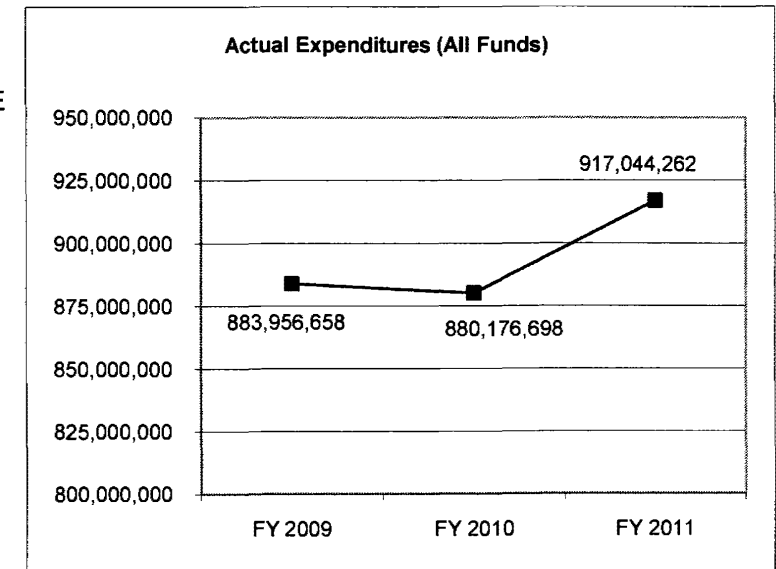
This core request is for ongoing funding to reimburse for hospital services and managed care premiums provided to MO HealthNet participants and the uninsured. Funding for this core is used to maintain hospital reimbursement at a sufficient level to ensure quality health care and provider participation. Hospitals are assessed a provider tax for the privilege of doing business in the state. The assessment is a general revenue equivalent and when used to make valid Medicaid payments, earns federal dollars. These earnings fund this FRA program appropriation.

## 3. PROGRAM LISTING (list programs included in this core funding)

Hospital - Federal Reimbursement Allowance

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	883,999,999	880,184,206	918,929,393	878,929,394 E
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	883,999,999	880,184,206	918,929,393	N/A
Actual Expenditures (All Funds)	883,956,658	880,176,698	917,044,262	N/A
Unexpended (All Funds)	43,341	7,508	1,885,131	N/A
Unexpended, by Fund:				
General Revenue				N/A
Federal				N/A
Other				N/A



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

Estimated "E" appropriation for FRA.



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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES**  
**FED REIMB ALLOWANCE**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	0	0	878,929,394	878,929,394	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>878,929,394</b>	<b>878,929,394</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	0	0	878,929,394	878,929,394	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>878,929,394</b>	<b>878,929,394</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	0	0	878,929,394	878,929,394	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>878,929,394</b>	<b>878,929,394</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
FED REIMB ALLOWANCE								
CORE								
PROFESSIONAL SERVICES	1,000,500	0.00	0	0.00	0	0.00	0	0.00
TOTAL - EE	1,000,500	0.00	0	0.00	0	0.00	0	0.00
PROGRAM DISTRIBUTIONS	916,043,762	0.00	878,929,394	0.00	878,929,394	0.00	0	0.00
TOTAL - PD	916,043,762	0.00	878,929,394	0.00	878,929,394	0.00	0	0.00
GRAND TOTAL	\$917,044,262	0.00	\$878,929,394	0.00	\$878,929,394	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00
OTHER FUNDS	\$917,044,262	0.00	\$878,929,394	0.00	\$878,929,394	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Federal Reimbursement Allowance (FRA)**

**Program is found in the following core budget(s): Federal Reimbursement Allowance (FRA)**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides ongoing reimbursement for hospital services and managed care premiums provided to MO HealthNet participants and the uninsured.*

The Federal Reimbursement Allowance (FRA) program provides payments for hospital inpatient services, outpatient services, managed care capitated payments, CHIP and Women's Health services (using the FRA assessment as general revenue equivalent). The FRA program supplements payments for the cost of providing care to Medicaid participants under Title XIX of the Social Security Act and to the uninsured. Hospitals are assessed a provider tax for the privilege of doing business in the state. The assessment is a general revenue equivalent and when used to make valid Medicaid payments, earns federal dollars. These earnings fund the FRA program.

Currently 147 hospitals participate in the FRA program. The FRA assessment is a percent of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. For the first quarter of FY 12, the assessment rate is 5.45% and 5.95% for the remaining 3 quarters, provided the federal maximum allowable assessment rate increases to 6% as anticipated. The net inpatient and net outpatient revenue are determined from the hospital's cost reports that are filed annually with the MO HealthNet Division. The MO HealthNet Division uses funds generated from the FRA program as the equivalent of General Revenue funds. The funds are distributed to the hospitals through a combination of payments.

The FRA program reimburses hospitals for certain costs as outlined below:

- Higher Inpatient Per Diems - Higher per diems were granted in October 1992 when the FRA program started. At that time, rates for the general plan hospitals were rebased to the 1990 cost reports. In April 1998, hospitals were rebased to the 1995 cost reports.
- Increased Outpatient Payment - 30% of outpatient costs are made through FRA funding. An outpatient prospective reimbursement methodology was implemented on July 1, 2002.
- Direct Medicaid Payments - The hospital receives additional lump sum payments to cover their unreimbursed costs for providing services to MO HealthNet participants. These payments, along with per diem payments, provide 100% of the allowable Medicaid cost for MO HealthNet participants.
- Uninsured Add-On - Payments for the cost of providing services to patients that do not have insurance (charity care and bad debts).
- Upper Payment Limit - An annual payment to hospitals to recognize costs up to what Medicare payment principles allow.
- Enhanced GME - An annual payment to hospitals for Graduate Medical Education (GME) cost inflation not reimbursed in the per diem, Direct Medicaid or quarterly GME payments.

This program also funds the following:

- Costs of the federally required independent DSH audits
- Missouri's Gateway to Better Health Medicaid demonstration. Prior to the new federal DSH audit rules, DSH funding was voluntarily paid by hospitals to safety net clinics that provided uncompensated ambulatory care at specific facilities. The new federal DSH audit requirements limit the amount of DSH hospitals can receive to each individual hospital's uncompensated Medicaid and uninsured costs. Under the Demonstration, CMS is allowing the state to continue to use DSH funds to preserve and improve primary and specialty health care services in St. Louis.
- IMD Demonstration. This is a three-year Medicaid emergency psychiatric demonstration project. The project would allow federal Medicaid matching payments for emergency psychiatric treatment in psychiatric hospitals that provide services to Medicaid beneficiaries between the ages of 21 and 64.

Currently, psychiatric hospitals are required to provide these emergency services under the Emergency Medical Treatment and Active Labor Act, but they cannot receive federal matching payments because of the rules prohibiting IMD's from receiving federal Medicaid reimbursement. The services eligible for federal payments under the demonstration projects are limited to emergency psychiatric treatment and stabilization.

**2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State statute: RSMo. 208.453; Federal law: Social Security Act Section 1903(w); Federal Regulation: 42 CFR 433 Subpart B.

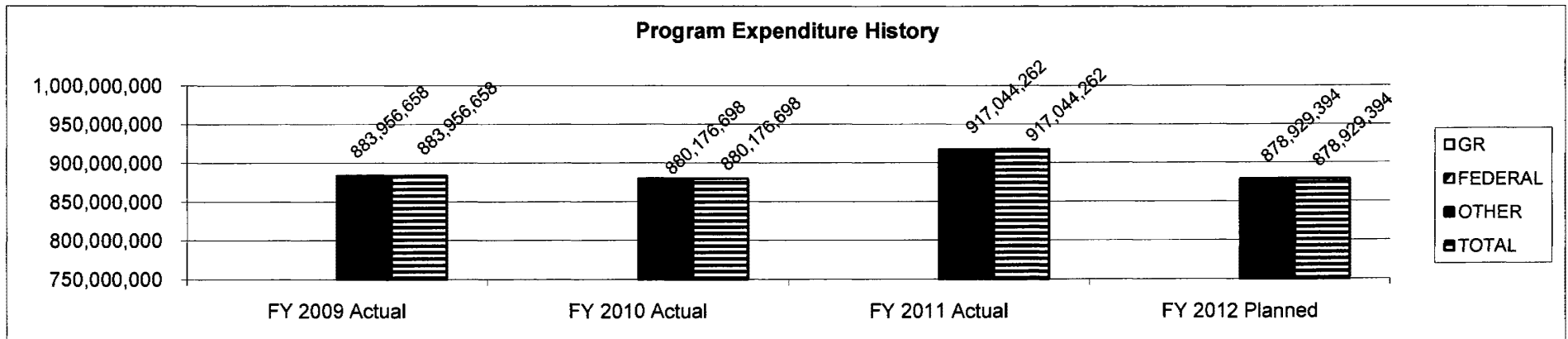
**3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY 12 is a blended 63.41% federal match. The state matching requirement is 36.59%. The hospital assessments serve as the general revenue equivalent to earn Medicaid federal reimbursement.

**4. Is this a federally mandated program? If yes, please explain.**

No.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



**6. What are the sources of the "Other " funds?**

Federal Reimbursement Allowance Fund (0142)

**7a. Provide an effectiveness measure.**

Effectiveness Measure: The Federal Reimbursement Allowance (FRA) is used as state match for administration costs and Medicaid services minimizing the need for General Revenue. In FY 2011, the FRA program provided over \$286 million in state match to fund various appropriations.

FRA as a Funding Source in the Various Appropriations	SFY			
	2009	2010	2011	2012
Revenue Max / Admin	\$100,133	\$100,133	\$100,133	\$100,133
Managed Care	\$109,065,009	\$93,533,441	\$93,533,441	\$93,533,441
Hospital	\$133,382,390	\$148,913,958	\$185,298,958	\$185,298,958
Women's Health Services	\$167,756	\$167,756	\$167,756	\$167,756
Show-Me Health (SB 306)*		\$52,615,793		
CHIP	\$7,719,204	\$7,719,204	\$7,719,204	\$7,719,204
Total	\$250,434,492	\$303,050,285	\$286,819,492	\$286,819,492

\*Appropriation contingent on passage of enabling legislation (SB 306). Enabling legislation did not pass.

**7b. Provide an efficiency measure.**

Efficiency Measure: The FRA tax assessment is a general revenue equivalent and when used to make Medicaid payments earns a federal match. In FY 2011, hospitals were assessed \$919.3 million in tax.

FRA Tax Assessments Revenues Obtained*	
SFY	
2009	\$847.2 mil
2010	\$885.1 mil
2011	\$919.3 mil
2012	\$1,008.9 mil estimated
2013	\$1,059.2 mil estimated
2014	\$1,112.2 mil estimated

\*Projections assume the federal government continues to allow tax rate maximum of 6%.

**7c. Provide the number of clients/individuals served, if applicable.**

FRA payments are made on behalf of MO HealthNet participants and the uninsured accessing hospital services.

**7d. Provide a customer satisfaction measure, if available.**

**NEW DECISION ITEM  
RANK: 20**

Department: Social Services  
Division: MO HealthNet  
DI Name: FRA Increase Authority

Budget Unit: 90553C  
DI#: 1886021

**1. AMOUNT OF REQUEST**

FY 2013 Budget Request			
GR	Federal	Other	Total
PS			
EE			
PSD		67,500,000	67,500,000
TRF			
Total		<b>67,500,000</b>	<b>67,500,000</b>
FTE			0.00

<b>Est. Fringe</b>	0	0	0	0
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*Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.*

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)

FY 2013 Governor's Recommendation			
GR	Federal	Other	Total
PS			
EE			
PSD			
TRF			
Total			
FTE			

<b>Est. Fringe</b>	0	0	0	0
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*Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.*

Other Funds:

**2. THIS REQUEST CAN BE CATEGORIZED AS:**

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Increase Budget Authority	

**3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.**

*PROGRAM SYNOPSIS: This item is needed to increase appropriation authority to reflect planned FY 2013 payments.*

Funding is needed to redistribute Medicaid Disproportionate Share Hospital (DSH) payments in order to be in compliance with hospital-specific DSH limit standards. Appropriation authority is also needed for an upper payment limit payment in lieu of the trauma payments appropriated in the Hospital Care Section.

**4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)**

In December 2008, the Centers for Medicare and Medicaid Services (CMS) issued a final regulation, effective January 19, 2009, mandating an independent audit of Medicaid disproportionate share hospital (DSH) payments to hospitals starting with DSH payment year 2005. Independent DSH audits are conducted 3 years after the DSH payment year. For example, the annual independent audit of SFY 2011 DSH payments will be done in 2014. A transition period was authorized by the federal DSH rules where findings would not be found for DSH payment years 2005-2010. The first year of audits conducted during 2010 included the independent audits for DSH payment years 2005, 2006 and 2007. The federal DSH audit rules and CMS guidance directed states to consider the findings from these audits when calculating uncompensated care cost estimates and associated DSH payments beginning with Medicaid State plan rate year 2011. The results of the 2005 – 2007 independent DSH audits indicated that the DSH cost and payment methodology used by MHD would not comply with the hospital-specific DSH limit standards. To reflect the methodology change and be in compliance with the hospital-specific DSH limit standards, adjustments will be made for the SFY 2011 DSH payments based on a state DSH survey and final adjustments will be made beginning with SFY 2011 DSH payments based on the results of the annual independent DSH audits. The Division will recoup DSH payments in excess of the hospital-specific DSH limit and redistribute those funds to hospitals whose payments are below their hospital-specific DSH limit, up to the federal DSH allotment. The federal share of any DSH payments recouped in excess of the federal DSH allotment must be returned to the federal government.

The SFY 2011 interim DSH payment adjustments based on the state DSH survey result in the following:

A total recoupment of approximately \$102.0 million.

Approximately \$81.5 million is expected to be recouped and redistributed in SFY 2012

Approximately \$17.5 million is expected to be recouped and redistributed in SFY 2013

Approximately \$3.0 million is left to be recouped and redistributed in SFY 2014, pending the outcome of the annual independent DSH audit.

This also requests appropriation authority to enable the state to make upper payment limit (UPL) payments in lieu of trauma payments appropriated in the Hospital Care section. The trauma center appropriations have not been used since FY 2008 since many trauma centers were unable to receive the payments under the criteria set forth in the Medicaid State Plan. MHD worked with the Centers for Medicaid and Medicare Services (CMS) to simplify the calculations and base payments on Medicaid utilization rather than trauma center criteria. This enables the department to maximize payments to hospitals under the new DSH audit rules while targeting those hospitals that serve a higher Medicaid population. Based on a FY 2011 estimate, approximately 131 hospitals will qualify based on Medicaid utilization. A corresponding core reduction is being requested in the Federal Reimbursement Allowance section. UPL payments reflect the difference between Medicaid payments and the amount Medicare would pay under Medicare principles.

	Total	GR	Federal	Other
DSH Redistribution	\$17,500,000	\$0	\$0	\$17,500,000
Upper Payment Limit Payment	\$50,000,000	\$0	\$0	\$50,000,000
Total	\$67,500,000	\$0	\$0	\$67,500,000

**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	0		0		67,500,000		67,500,000		
Total PSD	0		0		67,500,000		67,500,000		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	67,500,000	0.0	67,500,000	0.0	0

**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0



**6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)**

**6a. Provide an effectiveness measure.**

FRA as a Funding Source in the Various Appropriations	SFY			
	2009	2010	2011	2012
Revenue Max / Admin	\$100,133	\$100,133	\$100,133	\$100,133
Managed Care	\$109,065,009	\$93,533,441	\$93,533,441	\$93,533,441
Hospital	\$133,382,390	\$148,913,958	\$185,298,958	\$185,298,958
Women's Health Services	\$167,756	\$167,756	\$167,756	\$167,756
Show-Me Health (SB 306)*		\$52,615,793		
CHIP	\$7,719,204	\$7,719,204	\$7,719,204	\$7,719,204
Total	\$250,434,492	\$303,050,285	\$286,819,492	\$286,819,492

\*Appropriation contingent on passage of enabling legislation (SB 306). Enabling legislation did not pass.

**6b. Provide an efficiency measure.**

FRA Tax Assessments Revenues Obtained*	
SFY	
2009	\$847.2 mil
2010	\$885.1 mil
2011	\$919.3 mil
2012	\$1,008.9 mil estimated
2013	\$1,059.2 mil estimated
2014	\$1,112.2 mil estimated

\*Projections assume the federal government continues to allow tax rate maximum of 6%.

**6c. Provide the number of clients/individuals served, if applicable.**

FRA payments are made on behalf of MO HealthNet participants and the uninsured accessing hospit

**6d. Provide a customer satisfaction measure, if available.**

**7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:**

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>FED REIMB ALLOWANCE</b>								
<b>FRA Increase Authority - 1886021</b>								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	67,500,000	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	67,500,000	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$0</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>	<b>\$67,500,000</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$67,500,000	0.00		0.00

# **IGT Safety Net Hospitals**

# FY13 Department of Social Services Report #9

# DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN	
IGT SAFETY NET HOSPITALS									
CORE									
PROGRAM-SPECIFIC									
TITLE XIX-FEDERAL AND OTHER	122,232,173	0.00	129,505,748	0.00	129,505,748	0.00	0	0.00	
INTERGOVERNMENTAL TRANSFER	70,206,872	0.00	70,348,801	0.00	70,348,801	0.00	0	0.00	
TOTAL - PD	192,439,045	0.00	199,854,549	0.00	199,854,549	0.00	0	0.00	
TOTAL	192,439,045	0.00	199,854,549	0.00	199,854,549	0.00	0	0.00	
GRAND TOTAL	\$192,439,045	0.00	\$199,854,549	0.00	\$199,854,549	0.00	\$0	0.00	

# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: IGT Safety Net Hospitals

Budget Unit: 90571C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD		129,505,748	70,348,801	199,854,549 E
TRF				
Total		129,505,748	70,348,801	199,854,549 E
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Intergovernmental Transfers (0139)

Notes: An "E" is requested for \$70,348,801 Intergovernmental Transfers and \$129,505,748 Federal Funds.

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

## 2. CORE DESCRIPTION

This core request is for funding payments for MO HealthNet participants and the uninsured through intergovernmental transfers for safety net hospitals. Safety net hospitals traditionally see a high volume of MO HealthNet/uninsured patients.

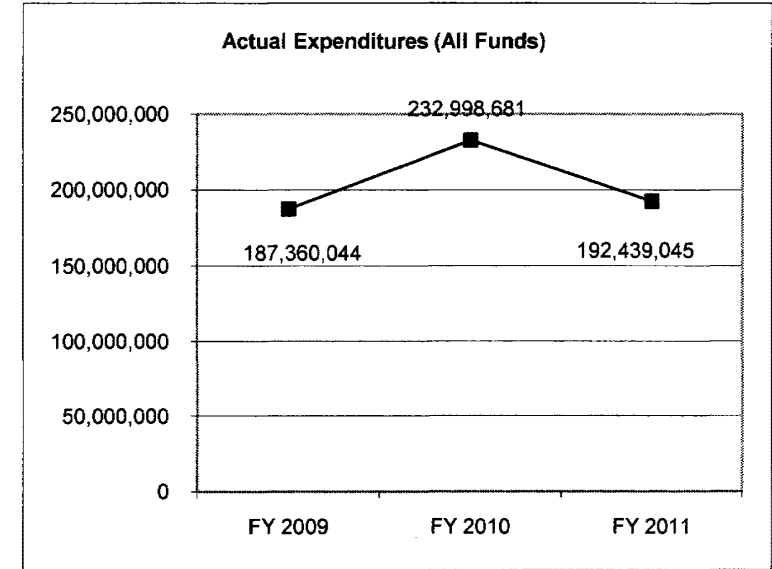
Payments from this program are made to the University of Missouri Hospitals and Clinics; Missouri Rehabilitation Center; Truman Medical Center Hospital-Hill; Truman Medical Center-Lakewood and the Department of Mental Health hospitals.

## 3. PROGRAM LISTING (list programs included in this core funding)

Intergovernmental transfers for Safety Net Hospitals.

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.	
Appropriation (All Funds)	187,360,100	234,904,000	199,854,549	199,854,549	E
Less Reverted (All Funds)	0	0	0	N/A	
Budget Authority (All Funds)	187,360,100	234,904,000	199,854,549	N/A	
Actual Expenditures (All Funds)	187,360,044	232,998,681	192,439,045	N/A	
Unexpended (All Funds)	56	1,905,319	7,415,504	N/A	
Unexpended, by Fund:					
General Revenue	0	N/A	0	N/A	
Federal	33	1,231,287	7,273,575	N/A	
Other	23	674,032	141,929	N/A	
	(1)	(2)			



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

Estimated "E" appropriation for Federal fund and Intergovernmental Transfers.

(1) The IGT Safety Net Hospitals program started in FY 2009.

(2) E increase of \$37,554,000 in Federal funds and \$18,150,000 in Intergovernmental Transfers.

**CORE RECONCILIATION DETAIL**

**DEPARTMENT OF SOCIAL SERVICES**  
**IGT SAFETY NET HOSPITALS**

**5. CORE RECONCILIATION DETAIL**

	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	0	129,505,748	70,348,801	199,854,549	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>129,505,748</b>	<b>70,348,801</b>	<b>199,854,549</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	0	129,505,748	70,348,801	199,854,549	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>129,505,748</b>	<b>70,348,801</b>	<b>199,854,549</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	0	129,505,748	70,348,801	199,854,549	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>129,505,748</b>	<b>70,348,801</b>	<b>199,854,549</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
IGT SAFETY NET HOSPITALS								
CORE								
PROGRAM DISTRIBUTIONS	192,439,045	0.00	199,854,549	0.00	199,854,549	0.00	0	0.00
TOTAL - PD	192,439,045	0.00	199,854,549	0.00	199,854,549	0.00	0	0.00
GRAND TOTAL	\$192,439,045	0.00	\$199,854,549	0.00	\$199,854,549	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$122,232,173	0.00	\$129,505,748	0.00	\$129,505,748	0.00		0.00
OTHER FUNDS	\$70,206,872	0.00	\$70,348,801	0.00	\$70,348,801	0.00		0.00



## PROGRAM DESCRIPTION

**Department:** Social Services

**Program Name:** IGT Safety Net Hospitals

**Program is found in the following core budget(s):** IGT Safety Net Hospitals

### 1. What does this program do?

*PROGRAM SYNOPSIS: This program provides payments for MO HealthNet participants and the uninsured through intergovernmental transfers for safety net hospitals. Safety net hospitals traditionally see a high volume of MO HealthNet/uninsured patients.*

Federal Medicaid regulation (42 CFR 433.51) allows state and local governmental units (including public providers) to transfer funds to the state as the non-federal share of Medicaid payments. These transfers are called intergovernmental transfers (IGTs). This funding maximizes eligible costs for federal Medicaid funds, utilizing current state and local funding sources as match for services.

In FY 2009, the MO HealthNet Division changed from a Certified Public Expenditure (CPE) process to an Intergovernmental Transfer (IGT) process for the non-federal share of hospital payments. The following state owned/operated hospitals and public hospitals are paid from this appropriation: (1) Metropolitan St. Louis Psychiatric Center; (2) Western Missouri Mental Health Center; (3) Hawthorne Children's Psychiatric Hospital; (4) Northwest Missouri Psychiatric Rehabilitation Center; (5) Fulton State Hospital; (6) Southeast Missouri Mental Health Center; (7) St. Louis Psychiatric Rehabilitation Center; (8) Missouri Rehabilitation Center; (9) University Hospital and Clinics; (10) Truman Medical Center – Hospital Hill; and (11) Truman Medical Center – Lakewood.

Under the IGT process, hospitals transfer the non-federal share of payments to the state prior to payments being made. The state pays out the total claimable amount including both federal and non-federal share. The state demonstrates that the non-federal share of the payments is transferred to, and under the administrative control of, the Medicaid agency (Department of Social Services) prior to the total computable payments being made to the hospitals.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, 208.153; Federal law: Social Security Act Sections 1905(a)(1) and (2)(d)(5)(h). Federal Regulations: 42 CFR 433.51 and 440.20.

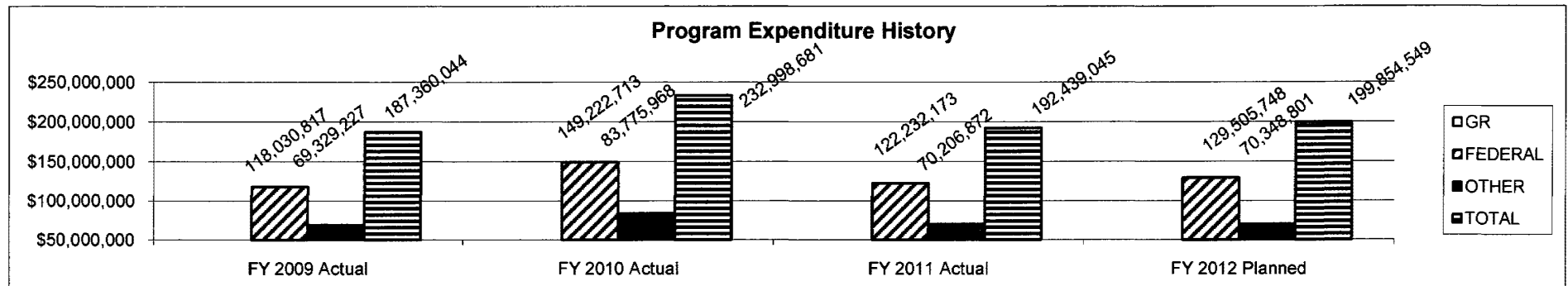
### 3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures made in accordance with the approved State Plan. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY 12 is a blended 63.41% federal match. The state matching requirement is 36.59%. For those public entities identified above who use state and local general revenue to provide eligible services to MO HealthNet participants, the MO HealthNet Division provides payment of the federal share for these eligible services.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



6. What are the sources of the "Other " funds?

Department of Social Services Intergovernmental Transfer Fund (0139)

7a. Provide an effectiveness measure.

7b. Provide an efficiency measure.

7c. Provide the number of clients/individuals served, if applicable.

7d. Provide a customer satisfaction measure, if available.

# **IGT DMH Medicaid Program**

# **FY13 Department of Social Services Report #9**

## **DECISION ITEM SUMMARY**

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>IGT DMH MEDICAID PROGRAM</b>								
CORE								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	117,051,753	0.00	112,898,554	0.00	112,898,554	0.00	0	0.00
INTERGOVERNMENTAL TRANSFER	66,638,708	0.00	65,731,662	0.00	65,731,662	0.00	0	0.00
TOTAL - PD	183,690,461	0.00	178,630,216	0.00	178,630,216	0.00	0	0.00
<b>TOTAL</b>	<b>183,690,461</b>	<b>0.00</b>	<b>178,630,216</b>	<b>0.00</b>	<b>178,630,216</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$183,690,461</b>	<b>0.00</b>	<b>\$178,630,216</b>	<b>0.00</b>	<b>\$178,630,216</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: IGT DMH Medicaid Program

Budget Unit: 90571C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD		112,898,554	65,731,662	178,630,216
TRF				
Total		112,898,554	65,731,662	178,630,216
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds: Intergovernmental Transfers (0139)

Note: An "E" is requested for \$65,731,662 Intergovernmental Transfers and \$112,898,554 Federal Funds.

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

## 2. CORE DESCRIPTION

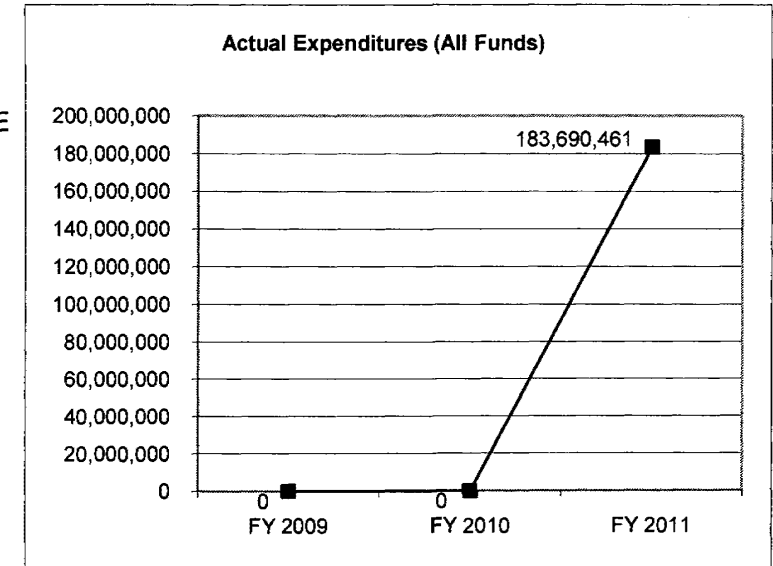
The core request is for funding payments for MO HealthNet participants and the uninsured through intergovernmental transfers for Community Psychiatric Rehabilitation (CPR) and Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) services.

## 3. PROGRAM LISTING (list programs included in this core funding)

Intergovernmental transfers for DMH Medicaid Program.

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.	
Appropriation (All Funds)	0	0	183,690,466	178,630,216	E
Less Reverted (All Funds)	0	0		N/A	
Budget Authority (All Funds)	0	0	183,690,466	N/A	
Actual Expenditures (All Funds)	0	0	183,690,461	N/A	
Unexpended (All Funds)	0	0	5	N/A	
Unexpended, by Fund:					
General Revenue	0	0	0	N/A	
Federal	0	0	0	N/A	
Other	0	0	0	N/A	
	(1)	(1)			



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

Estimated "E" appropriation for Federal fund and Intergovernmental Transfers.

(1) The IGT DMH Medicaid program started in FY 2011. Services provided by DMH prior to 2011.

**CORE RECONCILIATION DETAIL**

**DEPARTMENT OF SOCIAL SERVICES**  
**IGT DMH MEDICAID PROGRAM**

**5. CORE RECONCILIATION DETAIL**

	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	0	112,898,554	65,731,662	178,630,216	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>112,898,554</b>	<b>65,731,662</b>	<b>178,630,216</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	0	112,898,554	65,731,662	178,630,216	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>112,898,554</b>	<b>65,731,662</b>	<b>178,630,216</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	0	112,898,554	65,731,662	178,630,216	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>112,898,554</b>	<b>65,731,662</b>	<b>178,630,216</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
IGT DMH MEDICAID PROGRAM								
CORE								
PROGRAM DISTRIBUTIONS	183,690,461	0.00	178,630,216	0.00	178,630,216	0.00	0	0.00
TOTAL - PD	183,690,461	0.00	178,630,216	0.00	178,630,216	0.00	0	0.00
GRAND TOTAL	\$183,690,461	0.00	\$178,630,216	0.00	\$178,630,216	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$117,051,753	0.00	\$112,898,554	0.00	\$112,898,554	0.00		0.00
OTHER FUNDS	\$66,638,708	0.00	\$65,731,662	0.00	\$65,731,662	0.00		0.00



## PROGRAM DESCRIPTION

Department: Social Services

Program Name: IGT DMH Medicaid Program

Program is found in the following core budget(s): IGT DMH Medicaid Program

### 1. What does this program do?

*PROGRAM SYNOPSIS: This program provides payments for Community Psychiatric Rehabilitation (CPR) and Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR). The Department of Mental Health (DMH) uses a cost-based reimbursement methodology to pay for Community Psychiatric Rehabilitation (CPR) and Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) services. The state match is provided using an Intergovernmental Transfer process.*

Federal Medicaid regulation (42 CFR 433.51) allows state and local governmental units (including public providers) to transfer to the Medicaid agency the non-federal share of Medicaid payments. The amounts transferred are used as the state match to earn federal participation. These transfers are called intergovernmental transfers (IGTs). This funding maximizes eligible costs for federal Medicaid funds, utilizing current state and local funding sources as match for services.

Beginning in FY 11, the MO HealthNet Division changed from a Certified Public Expenditure (CPE) process to an Intergovernmental Transfer (IGT) process for the non-federal share of CPR and CSTAR services. This methodology allows DMH to be reimbursed 100% of CPR and CSTAR costs. MO HealthNet pays DMH a reasonable rate for the total costs of providing CPR and CSTAR services. The IGT transfer proves that the state match is available for the CPR and CSTAR programs. The appropriated transfer from General Revenue is in the DMH budget. Under this methodology, reimbursement rates are established for CSTAR and CPR services and the MHD will reimburse DMH both the state and the federal share for these services.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.152, 208.153; Federal law: Social Security Act Sections 1905(a)(1) and (2)(d)(5)(h). Federal Regulations: 42 CFR 433.51 and 440.20.

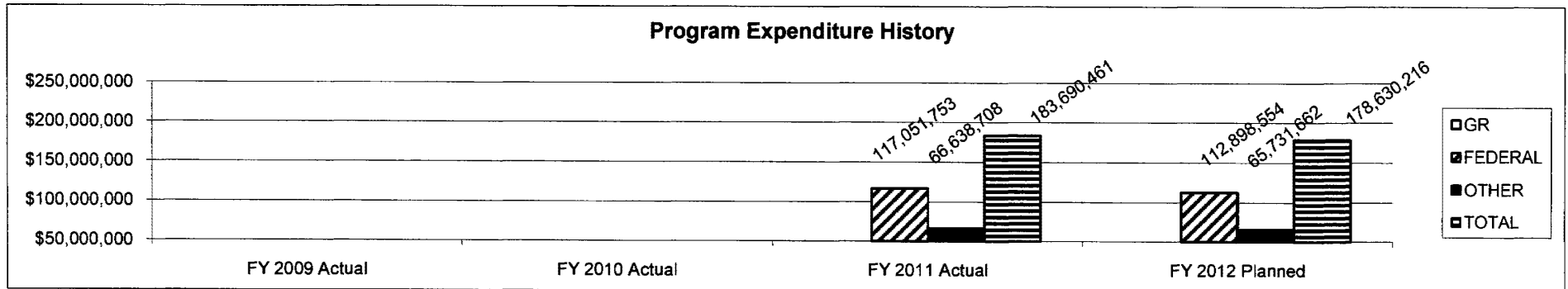
### 3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures made in accordance with the approved State Plan. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY12 is a blended 63.41% federal match. The state matching requirement is 36.59%. For those public entities identified above who use state and local general revenue to provide eligible services to MO HealthNet participants, the MO HealthNet Division provides payment of the federal share for these eligible services.

### 4. Is this a federally mandated program? If yes, please explain.

No.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



Program started in FY 2011.

**6. What are the sources of the "Other " funds?**

Department of Social Services Intergovernmental Transfer Fund (0139)

**7a. Provide an effectiveness measure.**

Effectiveness measures for this program can be found in the Department of Mental Health budget under Comprehensive Substance Treatment and Rehabilitation, Adult Community Programs - Community Treatment and Youth Community Programs - Community Treatment.

**7b. Provide an efficiency measure.**

Efficiency measures for this program can be found in the Department of Mental Health budget under Comprehensive Substance Treatment and Rehabilitation, Adult Community Programs - Community Treatment and Youth Community Programs - Community Treatment.

**7c. Provide the number of clients/individuals served, if applicable.**

The number of clients/individuals served for this program can be found in the Department of Mental Health budget under Comprehensive Substance Treatment and Rehabilitation, Adult Community Programs - Community Treatment and Youth Community Programs - Community Treatment.

**7d. Provide a customer satisfaction measure, if available.**

Customer satisfaction measures for this program can be found in the Department of Mental Health budget under Adult Community Programs - Community Treatment and Youth Community Programs - Community Treatment.

# **Women's Health Services**

# FY13 Department of Social Services Report #9

# DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>WOMEN'S HEALTH SRVC</b>								
<b>CORE</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	892,994	0.00	1,845,337	0.00	1,845,337	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	7,006,879	0.00	9,027,051	0.00	9,027,051	0.00	0	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	167,756	0.00	167,756	0.00	167,756	0.00	0	0.00
PHARMACY REIMBURSEMENT ALLOWAN	0	0.00	49,034	0.00	49,034	0.00	0	0.00
TOTAL - PD	8,067,629	0.00	11,089,178	0.00	11,089,178	0.00	0	0.00
<b>TOTAL</b>	<b>8,067,629</b>	<b>0.00</b>	<b>11,089,178</b>	<b>0.00</b>	<b>11,089,178</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Pharmacy PMPM Increase - 1886014</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	16,254	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	146,287	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	162,541	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>162,541</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$8,067,629</b>	<b>0.00</b>	<b>\$11,089,178</b>	<b>0.00</b>	<b>\$11,251,719</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: Women's Health Services

Budget Unit: 90554C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	\$1,845,337	\$9,027,051	\$216,790	\$11,089,178
TRF				
Total	<u>1,845,337</u>	<u>9,027,051</u>	<u>216,790</u>	<u>11,089,178</u>
FTE				0.00

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)  
Pharmacy Reimbursement Allowance Fund (0144)

Note: An "E" is requested for Federal Fund authority for \$1 for local initiatives.

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
<i>Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.</i>				

Other Funds:

Note:

## 2. CORE DESCRIPTION

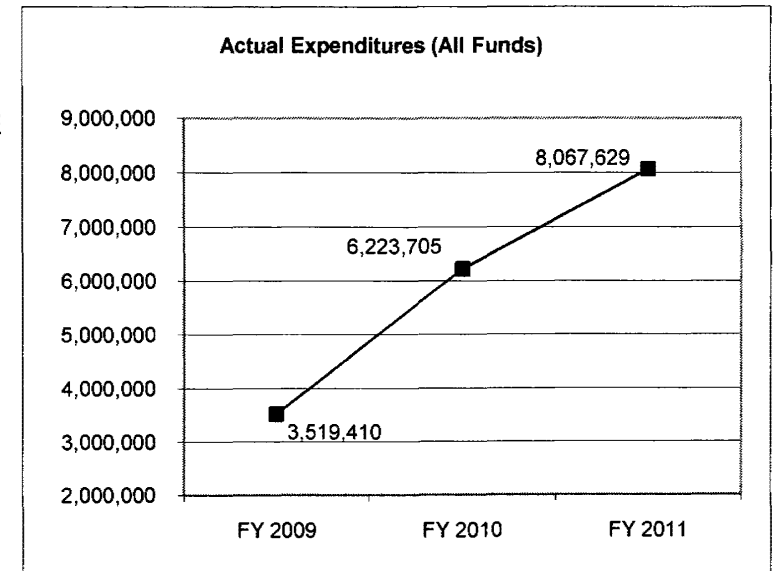
This core request is for ongoing funding for health care services provided to MO HealthNet participants covered through the 1115 Waiver. Funding for this core is used to provide coverage for women's health services.

## 3. PROGRAM LISTING (list programs included in this core funding)

Women's Health Services - 1115 Waiver

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.	
Appropriation (All Funds)	13,126,786	13,296,086	10,447,611	11,089,178	E
Less Reverted (All Funds)	(950,605)	(358,556)	0	N/A	
Budget Authority (All Funds)	12,176,181	12,937,530	10,447,611	N/A	
Actual Expenditures (All Funds)	3,519,410	6,223,705	8,067,629	N/A	
Unexpended (All Funds)	8,656,771	6,713,825	2,379,982	N/A	
Unexpended, by Fund:					
General Revenue	48	0	0	N/A	
Federal	8,626,312	6,664,791	2,330,948	N/A	
Other	30,411	49,034	49,034	N/A	
	(1)	(2) (3)	(4) (5)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

Estimated "E" appropriation for Federal fund authority for \$1 for local initiatives.

(1) Lapse of \$30,411 in Other (Pharmacy Reimbursement Allowance) is agency reserve.

(2) Lapse of \$49,034 in Other (Pharmacy Reimbursement Allowance) is agency reserve.

(3) Expenditures of \$102,666 were paid from the Supplemental Pool.

(4) Expenditures of \$569,812 were paid from the Supplemental Pool.

(5) Agency Reserve of \$49,034 Pharmacy Reimbursement Allowance Fund.

#### 4. FINANCIAL HISTORY

Cost Per Eligible	
	<b>Women's Health Services PMPM</b>
Pharmacy	\$2.15
Physician Related	\$10.50
EPSDT Services	\$0.01
Hospitals	\$0.39
Total	\$13.05

Health care entities use per member per month (PMPM) calculations as a benchmark to monitor, assess, and manage health care costs. The PMPM metric provides MHD management with a high level aggregate spending metric.

PMPM is calculated by dividing costs by the number of eligibles enrolled. Since caseload growth is accounted for when determining PMPM, the PMPM provides management with a better tool than just comparing overall increases in spending.

Source: Table 23 Medical Statistics for Fiscal Year 2011

CORE RECONCILIATION DETAIL

DEPARTMENT OF SOCIAL SERVICES  
WOMEN'S HEALTH SRVC

5. CORE RECONCILIATION DETAIL

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
TAFP AFTER VETOES							
	PD	0.00	1,845,337	9,027,051	216,790	11,089,178	
	<b>Total</b>	<b>0.00</b>	<b>1,845,337</b>	<b>9,027,051</b>	<b>216,790</b>	<b>11,089,178</b>	
DEPARTMENT CORE REQUEST							
	PD	0.00	1,845,337	9,027,051	216,790	11,089,178	
	<b>Total</b>	<b>0.00</b>	<b>1,845,337</b>	<b>9,027,051</b>	<b>216,790</b>	<b>11,089,178</b>	
GOVERNOR'S RECOMMENDED CORE							
	PD	0.00	1,845,337	9,027,051	216,790	11,089,178	
	<b>Total</b>	<b>0.00</b>	<b>1,845,337</b>	<b>9,027,051</b>	<b>216,790</b>	<b>11,089,178</b>	



# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>WOMEN'S HEALTH SRVC</b>								
<b>CORE</b>								
PROGRAM DISTRIBUTIONS	8,067,629	0.00	11,089,178	0.00	11,089,178	0.00	0	0.00
TOTAL - PD	8,067,629	0.00	11,089,178	0.00	11,089,178	0.00	0	0.00
<b>GRAND TOTAL</b>	<b>\$8,067,629</b>	<b>0.00</b>	<b>\$11,089,178</b>	<b>0.00</b>	<b>\$11,089,178</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>
GENERAL REVENUE	\$892,994	0.00	\$1,845,337	0.00	\$1,845,337	0.00		0.00
FEDERAL FUNDS	\$7,006,879	0.00	\$9,027,051	0.00	\$9,027,051	0.00		0.00
OTHER FUNDS	\$167,756	0.00	\$216,790	0.00	\$216,790	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Women's Health Services**

**Program is found in the following core budget(s): Women's Health Services**

### **1. What does this program do?**

*PROGRAM SYNOPSIS: Provides funding for health care services to MO HealthNet clients covered by an approved Centers for Medicare and Medicaid (CMS) 1115 waiver. Clients that are covered through the 1115 waiver receive Women's Health Services.*

Under the 1115 Waiver, uninsured women losing their MO HealthNet eligibility 60 days after the birth of their child are eligible for women's health services for one year (12 months). Legislation passed in FY 07 (SB 577) and an approved amendment to the CMS 1115 waiver resulted in the expansion of these services January 1, 2009 to uninsured women who are 18 to 55 years of age, have a net family income at or below 185% FPL with assets totaling less than \$250,000 and have no access to employer-sponsored health insurance covering family planning services. These new women are not limited to one year of coverage and remain eligible for the program as long as they continue to meet eligibility requirements and require family planning services. Women's health services are defined as:

- Department of Health and Human Services approved methods of contraception;
- Sexually transmitted disease testing and treatment, including pap tests and pelvic exams;
- Family planning counseling/education on various methods of birth control; and
- Drugs, supplies or devices related to the women's health services described above when they are prescribed by a physician or advanced practice nurse (subject to the national drug rebate program requirements).

### **2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State Statute: RSMo. 208.040, 208.151 and 208.659; Federal law: Social Security Act Sections 1115 and 1923(a)-(f); Federal Regulations: 42 CFR 433 Subpart B and 412.106.

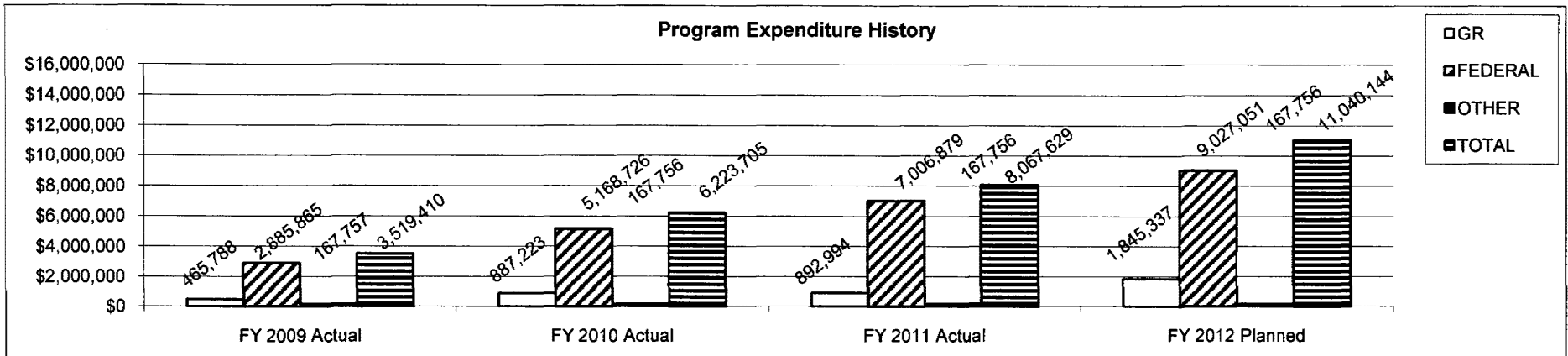
### **3. Are there federal matching requirements? If yes, please explain.**

Most of the services provided through the Women's Health Services program are eligible for an enhanced 90% federal match, requiring a state match of only 10%. The remaining services are matched at the federal medical assistance percentage (FMAP) calculated for MO HealthNet program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Missouri's FMAP for FY12 for these remaining services is a blended 63.41% federal match. The state matching requirement is 36.59%.

### **4. Is this a federally mandated program? If yes, please explain.**

No.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



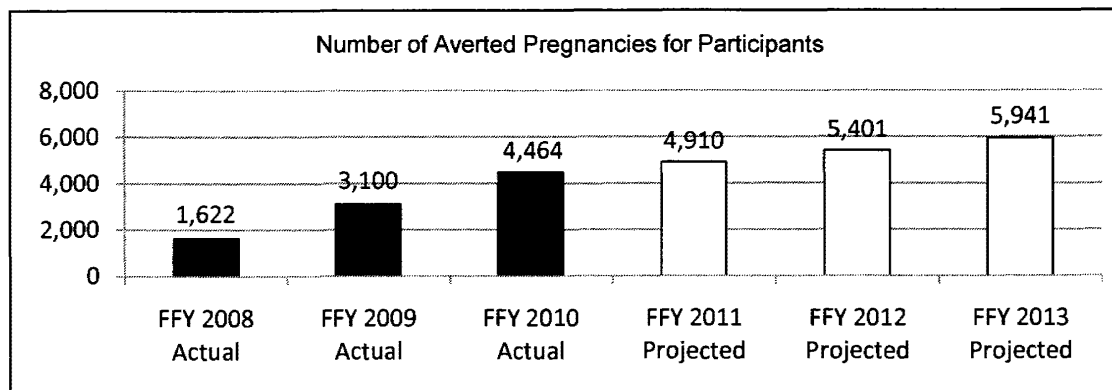
FY11 Reserves: \$49,034 Other Funds

**6. What are the sources of the "Other" funds?**

Federal Reimbursement Allowance Fund (0142) and Pharmacy Reimbursement Allowance Fund (0144).

**7a. Provide an effectiveness measure.**

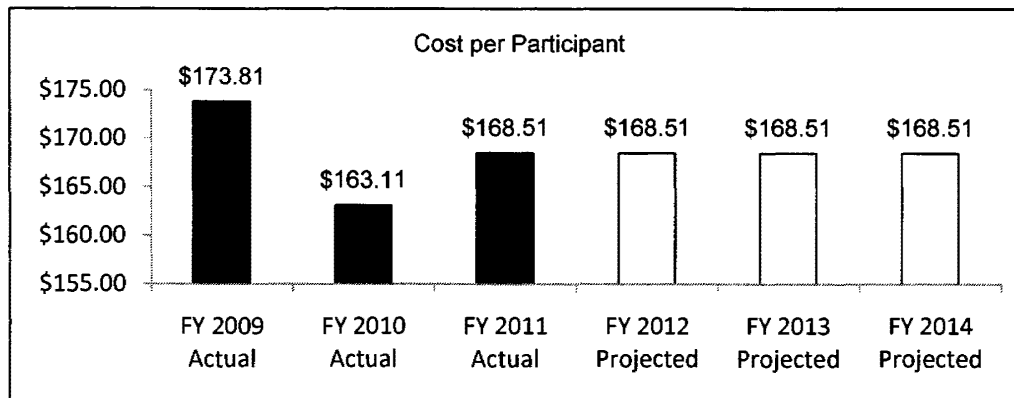
Effectiveness Measure: Increase the number of averted pregnancies for participants. The Women's Health Services program provides family planning services to women assisting them in avoiding unintended pregnancies.



Prior year numbers have been updated with more accurate data.

**7b. Provide an efficiency measure.**

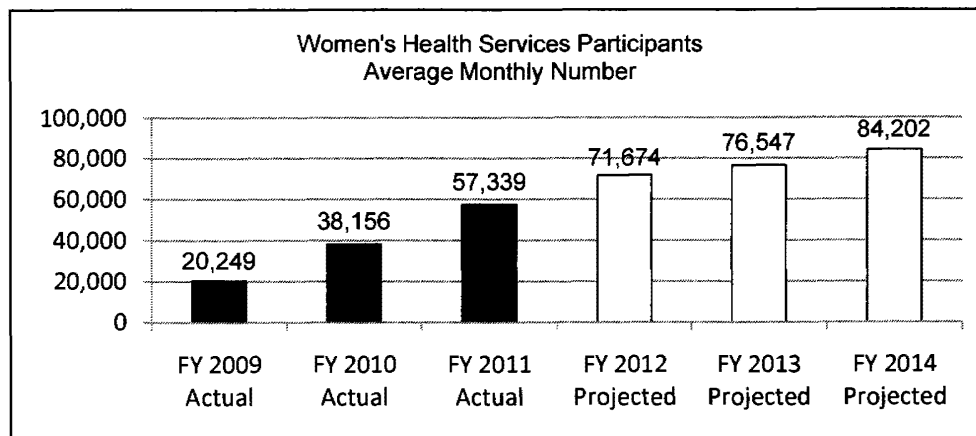
Efficiency Measure: Provide education and outreach to encourage women to access family planning services. Over 57,000 participants accessed family planning services in FY 2011 at a cost of \$9.4 million. The cost per participant was \$169.



Prior year numbers have been updated with more accurate data.

**7c. Provide the number of clients/individuals served, if applicable.**

SB 577 (FY07) and an approved amendment to the CMS 1115 waiver provided for an expansion of Women's Health Services to women 18 to 55 years of age with a net family income of 185% FPL or below, with assets less than \$250,000 and no access to employer sponsored insurance covering family planning services. Expanded services began January 1, 2009. The figures in the chart below are based on the average monthly number of participants enrolled in the program for each fiscal year.

**7d. Provide a customer satisfaction measure, if available.**

**CHIP**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>CHILDREN'S HEALTH INS PROGRAM</b>								
<b>CORE</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	23,277,111	0.00	27,758,255	0.00	27,758,255	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	116,118,899	0.00	132,983,811	0.00	132,983,811	0.00	0	0.00
PHARMACY REBATES	225,430	0.00	225,430	0.00	225,430	0.00	0	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	7,719,204	0.00	7,719,204	0.00	7,719,204	0.00	0	0.00
PHARMACY REIMBURSEMENT ALLOWAN	0	0.00	907,611	0.00	907,611	0.00	0	0.00
MO HEALTHNET MANAGED CARE ORG	40	0.00	1	0.00	1	0.00	0	0.00
HEALTH INITIATIVES	5,214,309	0.00	5,375,576	0.00	5,375,576	0.00	0	0.00
LIFE SCIENCES RESEARCH TRUST	171,206	0.00	171,206	0.00	171,206	0.00	0	0.00
PREMIUM	2,406,946	0.00	2,592,452	0.00	2,592,452	0.00	0	0.00
TOTAL - PD	155,133,145	0.00	177,733,546	0.00	177,733,546	0.00	0	0.00
<b>TOTAL</b>	<b>155,133,145</b>	<b>0.00</b>	<b>177,733,546</b>	<b>0.00</b>	<b>177,733,546</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Caseload Growth - 1886006</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	305,996	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	868,652	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	1,174,648	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>1,174,648</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Managed Care Actuarial Increas - 1886008</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	1,243,058	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	3,528,758	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	4,771,816	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>4,771,816</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Pharmacy PMPM Increase - 1886014</b>								
PROGRAM-SPECIFIC								
GENERAL REVENUE	0	0.00	0	0.00	443,581	0.00	0	0.00

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# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
CHILDREN'S HEALTH INS PROGRAM								
Pharmacy PMPM Increase - 1886014								
PROGRAM-SPECIFIC								
TITLE XIX-FEDERAL AND OTHER	0	0.00	0	0.00	1,259,227	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	1,702,808	0.00	0	0.00
TOTAL	0	0.00	0	0.00	1,702,808	0.00	0	0.00
GRAND TOTAL	\$155,133,145	0.00	\$177,733,546	0.00	\$185,382,818	0.00	\$0	0.00

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# CORE DECISION ITEM

Department: Social Services  
 Division: MO HealthNet  
 Core: Children's Health Insurance Program (CHIP)

Budget Unit: 90556C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE				
PSD	27,758,255	132,983,811	16,991,480	177,733,546 E
TRF				
Total	27,758,255	132,983,811	16,991,480	177,733,546
FTE			0.00	

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds: Federal Reimbursement Allowance Fund (FRA) (0142)  
 Managed Care Org Reimb Allowance Fund (0160)  
 Health Initiative Fund (HIF) (0275)  
 Pharmacy Rebates Fund (0114)  
 Pharmacy Reimbursement Allowance Fund (0144)  
 Premium Fund (0885)  
 Life Sciences Research Trust Fund (0763)

Note: An "E" is requested for \$1 Managed Care Organization Reimbursement Allowance.

	FY 2013 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

## 2. CORE DESCRIPTION

This core request is for ongoing funding for health care services provided to MO HealthNet clients. The Children's Health Insurance Program (CHIP) Title XXI funds are utilized for this expanded MO HealthNet population. Funding for this core is used to provide coverage for uninsured children.

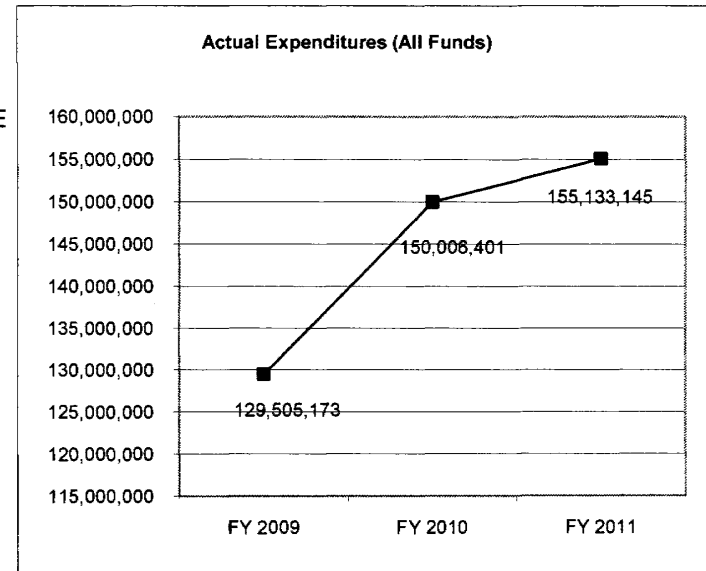
## 3. PROGRAM LISTING (list programs included in this core funding)

Children's Health Insurance Program (CHIP)



#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	187,544,853	190,849,618	156,387,490	177,733,546 E
Less Reverted (All Funds)	(161,267)	(9,081,038)	(161,267)	N/A
Budget Authority (All Funds)	187,383,586	181,768,580	156,226,223	N/A
Actual Expenditures (All Funds)	129,505,173	150,006,401	155,133,145	N/A
Unexpended (All Funds)	57,878,413	31,762,179	1,093,078	N/A
Unexpended, by Fund:				
General Revenue	4,250,806	0	0	N/A
Federal	40,601,135	30,092,912	0	N/A
Other	13,026,472	1,669,267	1,093,078	N/A
	(1)	(2)	(3)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

An "E" is requested for \$1 Managed Care Organization Allowance.

(1) Agency reserve of \$50,170,598: \$201,394 in Pharmacy Reimbursement Allowance, \$4,300,000 in Premium Fund (empty authority); \$7,719,204 in Federal Reimbursement Allowance (not included in the FY 2009 FRA assessment); \$33,700,000 in Federal Fund (empty authority); and \$4,250,000 in General Revenue Fund authority.

(2) Agency reserve of \$1,369,563: \$907,611 in Pharmacy Reimbursement Allowance and \$461,952 in Premium Fund.

(3) Agency reserve of \$919,563: \$907,611 in Pharmacy Reimbursement Allowance and \$11,952 in Premium Fund.

#### 4. FINANCIAL HISTORY

CHIP Cost Per Eligible	
	CHIP PMPM
Pharmacy	\$51.28
Physician Related	\$14.22
Dental	\$1.99
In-Home Services	\$0.02
Rehab & Specialty	\$1.97
EPSDT Services	\$11.29
Managed Care	\$82.04
Hospitals	\$20.97
Mental Health Services	\$7.69
Services provided in State Inst	\$1.45
Total	\$192.92

Health care entities use per member per month calculations as a benchmark to monitor, assess, and manage health care costs. The PMPM metric provides MHD management with a high level aggregate spending metric.

PMPM is calculated by dividing costs by the number of eligibles enrolled. Since caseload growth is accounted for when determining PMPM, the PMPM provides management with a better tool than just comparing overall increases in spending.

Mental Health Services and Services provided in a State Institution are not part of this core.

Source: Table 23 Medical Statistics for Fiscal Year 2011

**CORE RECONCILIATION DETAIL**

**DEPARTMENT OF SOCIAL SERVICES  
CHILDREN'S HEALTH INS PROGRAM**

**5. CORE RECONCILIATION DETAIL**

	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	27,758,255	132,983,811	16,991,480	177,733,546	
	<b>Total</b>	<b>0.00</b>	<b>27,758,255</b>	<b>132,983,811</b>	<b>16,991,480</b>	<b>177,733,546</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	27,758,255	132,983,811	16,991,480	177,733,546	
	<b>Total</b>	<b>0.00</b>	<b>27,758,255</b>	<b>132,983,811</b>	<b>16,991,480</b>	<b>177,733,546</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	27,758,255	132,983,811	16,991,480	177,733,546	
	<b>Total</b>	<b>0.00</b>	<b>27,758,255</b>	<b>132,983,811</b>	<b>16,991,480</b>	<b>177,733,546</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
CHILDREN'S HEALTH INS PROGRAM								
CORE								
PROGRAM DISTRIBUTIONS	155,133,145	0.00	177,733,546	0.00	177,733,546	0.00	0	0.00
TOTAL - PD	155,133,145	0.00	177,733,546	0.00	177,733,546	0.00	0	0.00
GRAND TOTAL	\$155,133,145	0.00	\$177,733,546	0.00	\$177,733,546	0.00	\$0	0.00
GENERAL REVENUE	\$23,277,111	0.00	\$27,758,255	0.00	\$27,758,255	0.00		0.00
FEDERAL FUNDS	\$116,118,899	0.00	\$132,983,811	0.00	\$132,983,811	0.00		0.00
OTHER FUNDS	\$15,737,135	0.00	\$16,991,480	0.00	\$16,991,480	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Children's Health Insurance Program (CHIP)**

**Program is found in the following core budget(s): Children's Health Insurance Program (CHIP)**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides for eligibility for health care services to MO HealthNet clients covered through a combination of a Medicaid State Plan for children whose families have income of 150% of the federal poverty level (FPL) or below and a Children's Health Insurance Program (CHIP) State Plan for children whose families have income over 150% of the FPL. CHIP provides coverage to uninsured children above existing MO HealthNet eligibility limits up to 300% of the FPL.*

The Children's Health Insurance Program is integrated into Missouri's MO HealthNet coverage. This integration was made possible through the passage of Senate Bill 632 of the second regular session of the 89th General Assembly (1998). Senate Bill 632 expanded the MO HealthNet program for children with family incomes from 200% to 300% of the federal poverty level.

Using CHIP, Missouri continues its commitment to improve medical care for its low income children by increasing their access to comprehensive medical services.

Eligible children must be under age 19, have a family income below 300% of the federal poverty level, be uninsured for six months or more, and have no access to other health insurance coverage for less than \$69 to \$174 per month during SFY12 based on family size and income. Any child identified as having special health care needs (defined as a condition which left untreated would result in the death or serious physical injury of a child) who does not have access to affordable employer-subsidized health care insurance will not be required to be without health care coverage for six months in order to be eligible for services. They are also not subject to the waiting period as long as the child meets all other qualifications for eligibility.

Uninsured children with family income of 150% FPL or below receive a package of benefits equal to MO HealthNet coverage. Uninsured children with family income above 150% FPL receive a package of benefits equal to MO HealthNet coverage, excluding non-emergency medical transportation. Parents of children eligible for coverage above 150% and below 300% of the federal poverty level must show parental responsibility through the following:

- participation in immunization and wellness programs;
- furnishing the uninsured child's social security number;
- cooperation with third party insurance carriers;
- sharing in their children's health care costs through premiums.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 208.631 through 208.657; Federal law: Social Security Act, Title XXI; Federal Regulations: 42 CFR 457.

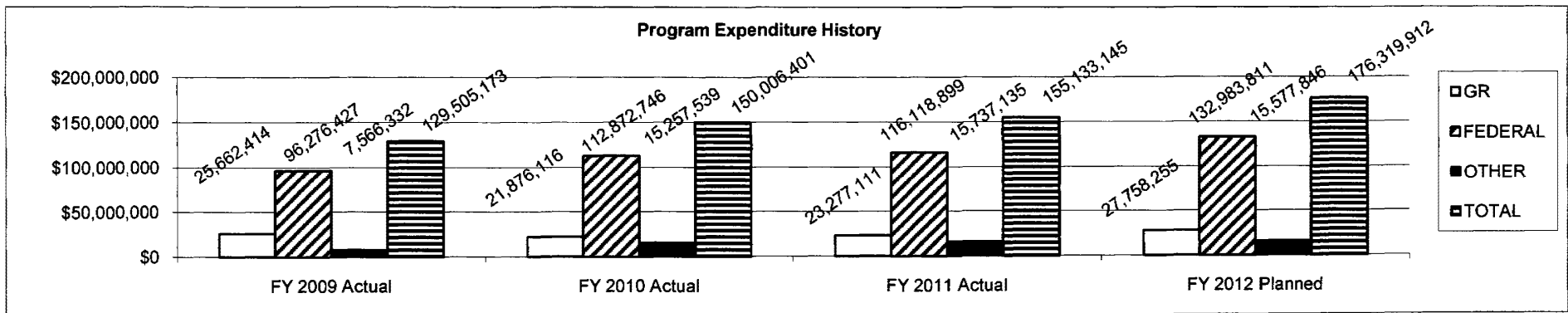
**3. Are there federal matching requirements? If yes, please explain.**

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Missouri's enhanced CHIP FMAP for FY12 is a blended 74.39% federal match. The state matching requirement for the CHIP program is 25.61%.

**4. Is this a federally mandated program? If yes, please explain.**

No.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



FY12 Reserve: \$1,252,367 Other Funds

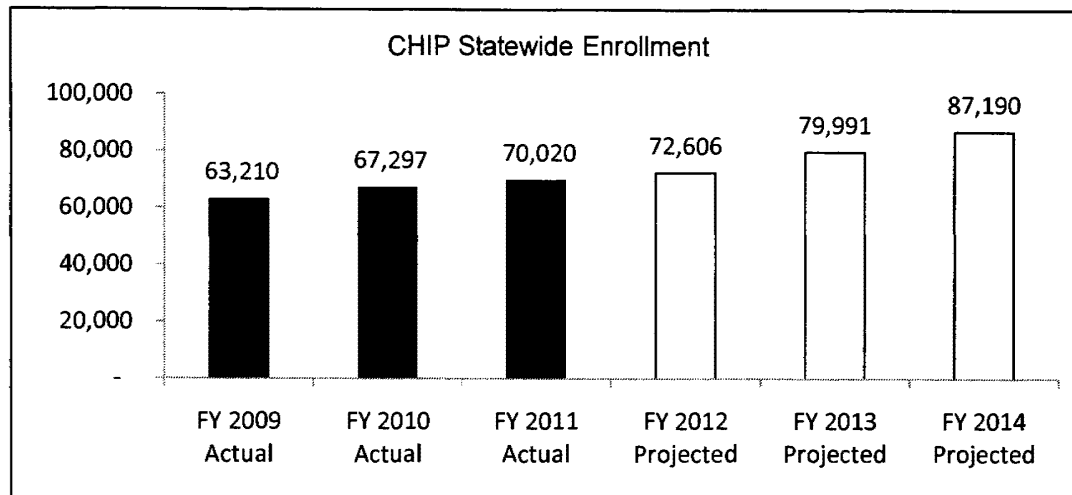
FY12 Reverted: \$161,267 Other Funds

**6. What are the sources of the "Other" funds?**

Pharmacy Rebates Fund (0114), Federal Reimbursement Allowance Fund (0142), Pharmacy Reimbursement Allowance Fund (0144), Health Initiatives Fund (0275), Premium Fund (0885), MO HealthNet Managed Care Organization Reimbursement Allowance Fund (0160), Life Sciences Research Trust Fund (0763).

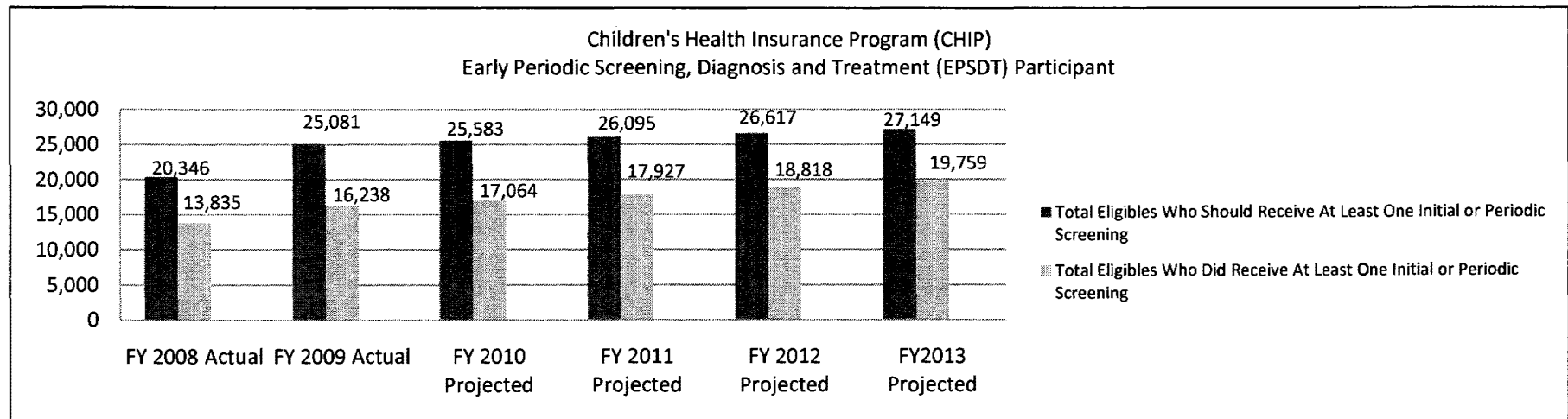
**7a. Provide an effectiveness measure.**

The CHIP program continues to provide health care coverage to thousands of Missouri's children. These children would be uninsured without CHIP coverage.



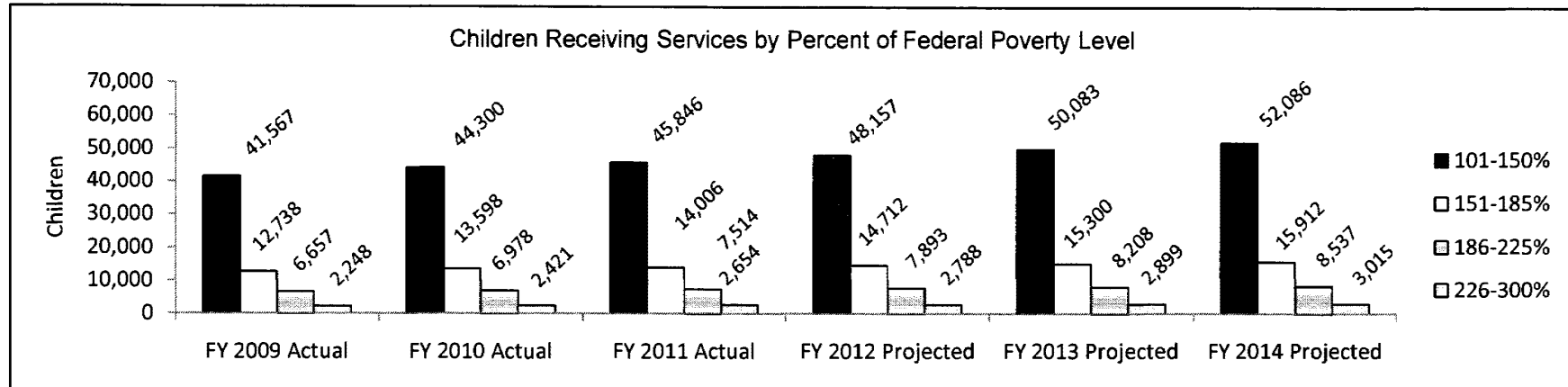
**7b. Provide an efficiency measure.**

The CHIP program provides uninsured children with Early Periodic Screening, Diagnosis and Treatment services.



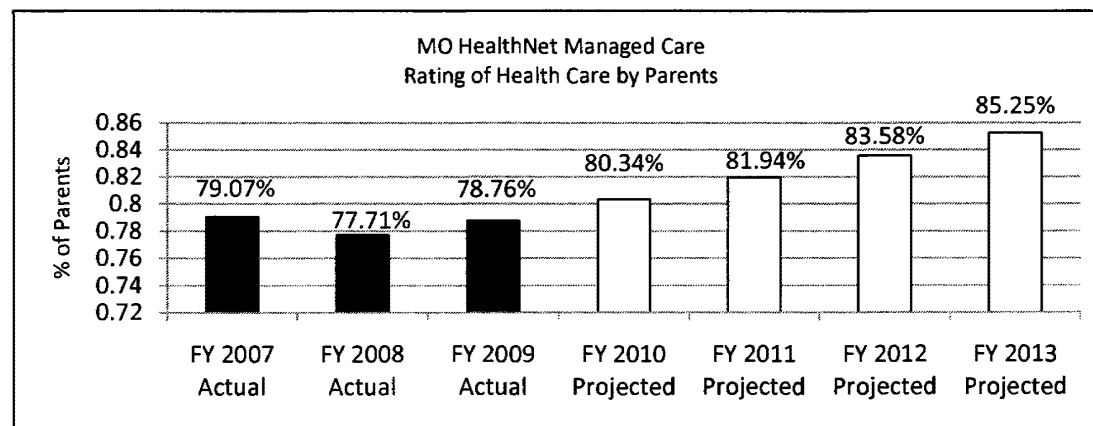
**7c. Provide the number of clients/individuals served, if applicable.**

Participants are children above the existing Title XIX Medicaid eligibility up to 300% of the federal poverty level (FPL). As of September 2005, children in the categories from 151-300% of the federal poverty level (FPL) are required to pay premiums.



**7d. Provide a customer satisfaction measure, if available.**

Children with CHIP coverage who reside in a MO HealthNet Managed Care region, receive their services from the MO HealthNet Managed Care health plans. Participants enrolled in MO HealthNet Managed Care health plans reported their satisfaction with the program on a scale of 0 to 10. 0 was the worst care possible and a 10 was the best care possible. The percentage of participants reporting an 8, 9, or 10 is reported in the chart below.





# **Nursing Facility Federal Reimbursement Allowance**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
NURSING FACILITY FED REIMB AL								
CORE								
PROGRAM-SPECIFIC								
NURSING FACILITY FED REIM ALLW	207,727,946	0.00	235,091,756	0.00	235,091,756	0.00	0	0.00
TOTAL - PD	207,727,946	0.00	235,091,756	0.00	235,091,756	0.00	0	0.00
TOTAL	207,727,946	0.00	235,091,756	0.00	235,091,756	0.00	0	0.00
NFFRA Increase Authority - 1886022								
PROGRAM-SPECIFIC								
NURSING FACILITY FED REIM ALLW	0	0.00	0	0.00	41,735,962	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	41,735,962	0.00	0	0.00
TOTAL	0	0.00	0	0.00	41,735,962	0.00	0	0.00
GRAND TOTAL	\$207,727,946	0.00	\$235,091,756	0.00	\$276,827,718	0.00	\$0	0.00

# CORE DECISION ITEM

Department: Social Services

Budget Unit: 90567C

Division: MO HealthNet

Core: Nursing Facilities Federal Reimbursement Allowance (NFFRA) Payments

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request			
GR	Federal	Other	Total
PS			
EE			
PSD		235,091,756	235,091,756
TRF			
Total		235,091,756	235,091,756
FTE			0.00

<b>Est. Fringe</b>	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds: Nursing Facility Federal Reimb Allowance Fund (NFFRA) (0196)

Note: An "E" is requested for the Nursing Facility Federal Reimbursement Allowance Fund.

FY 2013 Governor's Recommendation			
GR	Federal	Other	Total
PS			
EE			
PSD			
TRF			
Total		0	0
FTE			0.00

<b>Est. Fringe</b>	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

## 2. CORE DESCRIPTION

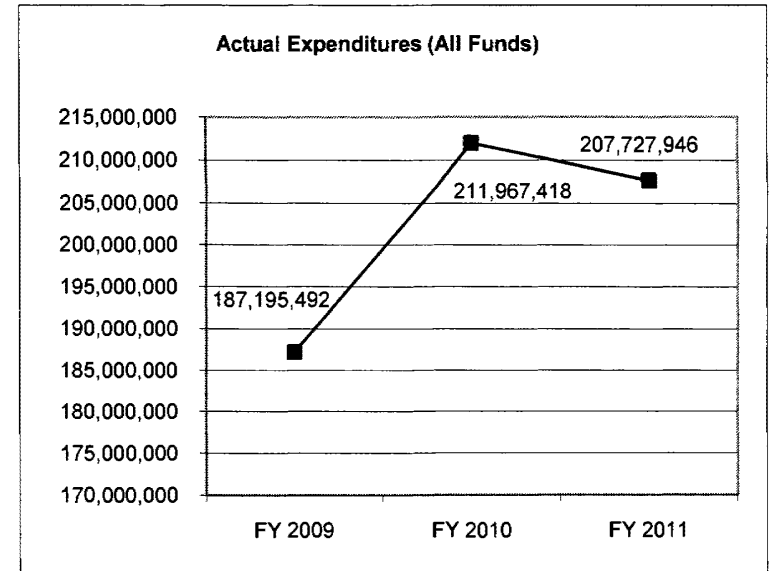
This core request is for ongoing funding for payments for long term care for Title XIX participants. Funds from this core are used to provide enhanced payment rates for improving the quality of patient care using the Nursing Facility Federal Reimbursement Allowance under the Title XIX of the Social Security Act as General Revenue equivalent. Nursing facilities are assessed a provider tax for the privilege of doing business in the state. The assessment is a general revenue equivalent, and when used to make valid Medicaid payments, earns federal dollars. These earnings fund this NFFRA program appropriation.

## 3. PROGRAM LISTING (list programs included in this core funding)

Nursing Facilities Federal Reimbursement Allowance (NFFRA) Program

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.	
Appropriation (All Funds)	213,840,231	235,091,756	235,091,756	235,091,756	E
Less Reverted (All Funds)	0	0	0	N/A	
Budget Authority (All Funds)	213,840,231	235,091,756	235,091,756	N/A	
Actual Expenditures (All Funds)	187,195,492	211,967,418	207,727,946	N/A	
Unexpended (All Funds)	26,644,739	23,124,338	27,363,810	N/A	
Unexpended, by Fund:					
General Revenue	0	0	0	N/A	
Federal	0	0	0	N/A	
Other	26,644,739	23,124,338	27,363,810	N/A	
	(1)		(2)		



#### NOTES:

Estimated "E" appropriation authority for NFFRA fund.

(1) Lapse of \$26,644,738 is excess authority.

(2) Agency reserve of \$8,788,019 in NFFRA fund.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES****NURSING FACILITY FED REIMB AL**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	0	0	235,091,756	235,091,756	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>235,091,756</b>	<b>235,091,756</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	0	0	235,091,756	235,091,756	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>235,091,756</b>	<b>235,091,756</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	0	0	235,091,756	235,091,756	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>0</b>	<b>235,091,756</b>	<b>235,091,756</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
NURSING FACILITY FED REIMB AL								
CORE								
PROGRAM DISTRIBUTIONS	207,727,946	0.00	235,091,756	0.00	235,091,756	0.00	0	0.00
TOTAL - PD	207,727,946	0.00	235,091,756	0.00	235,091,756	0.00	0	0.00
GRAND TOTAL	\$207,727,946	0.00	\$235,091,756	0.00	\$235,091,756	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00
OTHER FUNDS	\$207,727,946	0.00	\$235,091,756	0.00	\$235,091,756	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: Nursing Facilities Federal Reimbursement Allowance (NFFRA) Payments**

**Program is found in the following core budget(s): Nursing Facilities Federal Reimbursement Allowance (NFFRA) Payments**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides enhanced payments for long-term care for MO HealthNet participants.*

The Nursing Facilities Federal Reimbursement Allowance (NFFRA) program assesses nursing facilities in the state a fee for the privilege of doing business in the state. The funds collected by the state are used to fund the MO HealthNet Nursing Facility program and are used as state match for federal funding. In FY11, approximately 520 nursing facilities were assessed, and an average of 505 nursing facilities participated in the MO HealthNet program and received enhanced reimbursement. In FY 2012, the federal maximum allowable provider tax assessment limit is anticipated to increase from 5.5% to 6% effective October 1, 2011. The NFFRA rate will be \$9.27 per patient occupancy day July through September 2011 and the NFFRA rate will increase to \$11.70 per patient occupancy day effective October 2011, provided the federal maximum allowable assessment rate increases to 6% as anticipated, and will fund a portion of the nursing facility per diem reimbursement rate.

In FY 1995, the Nursing Facilities Federal Reimbursement Allowance program was implemented as part of a total restructuring of reimbursement for nursing homes. Reimbursement methodologies were changed to develop a cost component system. The components are patient care, ancillary, administration, and capital. A working capital allowance, incentives and the Nursing Facility Reimbursement Allowance (NFFRA) are also elements of the total reimbursement rate. Patient care includes nursing, medical supplies, activities, social services, and dietary costs. Ancillary services are therapies, barber and beauty shop, laundry, and housekeeping. Administration includes plant operation and administrative costs. Capital costs are reimbursed through a fair rental value methodology. The capital component includes five types of costs: rental value, return, computed interest, borrowing costs and pass-through expenses. Property insurance and real estate and personal property taxes (the pass-through expenses) are the only part of the capital component that is trended. The working capital allowance per diem rate is equal to 1.1 months of the total of the facility's per diem rates for the patient care, ancillary and administration cost components multiplied by the prime rate plus 2%. Incentives are paid to encourage patient care expenditures and cost efficiencies in administration. The patient care incentive is 10% of a facility's patient care per diem up to a maximum of 130% of the patient care median. The ancillary incentive is paid to all facilities whose costs are below the ancillary ceiling. The amount is one-half the difference between certain parameters. The multiple component incentive is allowed for facilities whose patient care and ancillary per diem are between 60 - 80% of total per diem and an additional amount is allowed for facilities with high MO HealthNet utilization.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: RSMo. 198.401; Federal law: Social Security Act Section 1903(w); Federal Regulation: 42 CFR 443, Subpart B

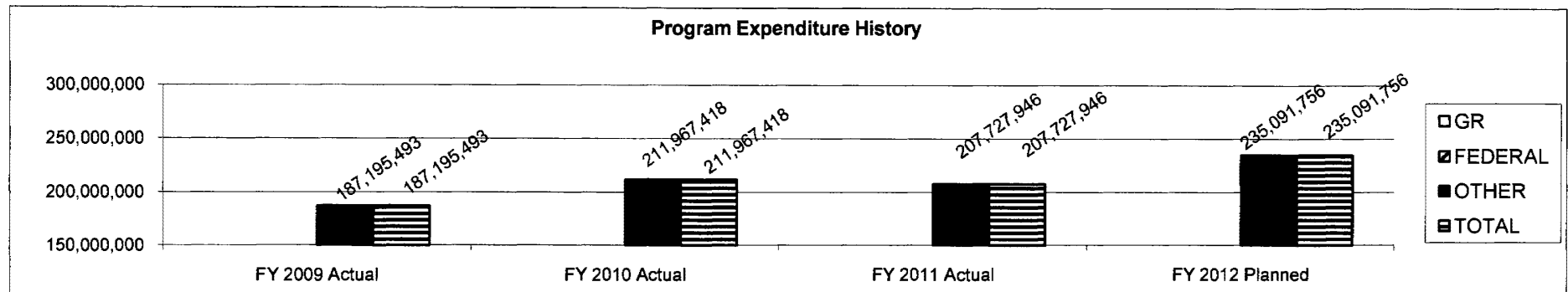
### 3. Are there federal matching requirements? If yes, please explain.

States can earn the federal medical assistance percentage (FMAP) on MO HealthNet program expenditures made in accordance with the approved State Plan. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY 12 is a blended 63.41% federal match. The state matching requirement is 36.59%. The nursing facility assessments serve as the general revenue equivalent to earn Medicaid federal reimbursement.

4. Is this a federally mandated program? If yes, please explain.

No.

5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.

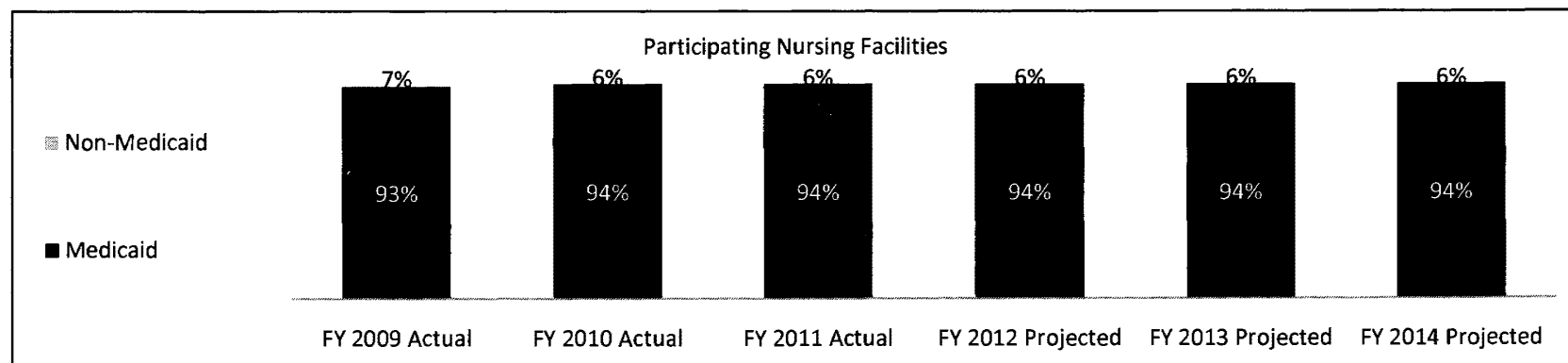


6. What are the sources of the "Other " funds?

Nursing Facility Federal Reimbursement Allowance Fund (0196)

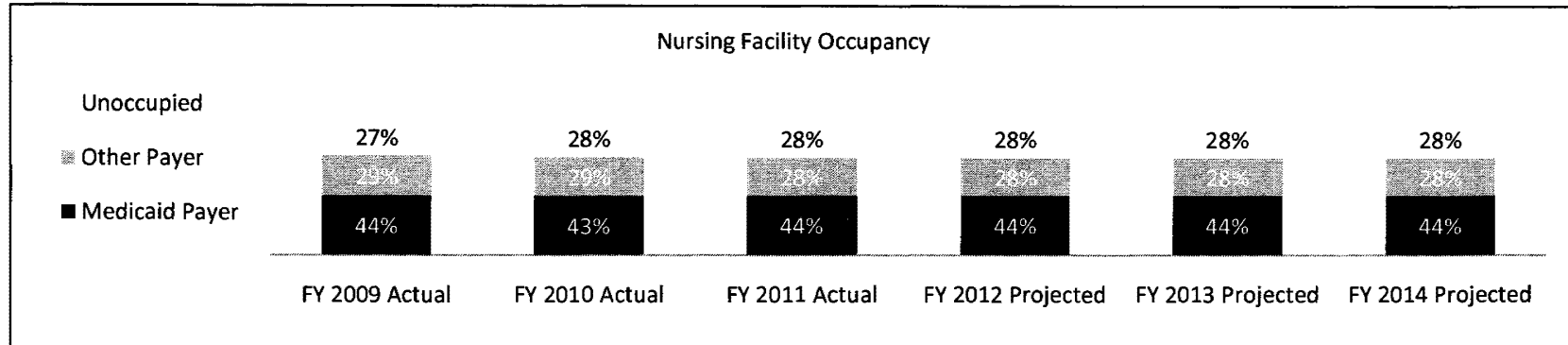
7a. Provide an effectiveness measure.

Effectiveness Measure 1: Provide reimbursement that is sufficient to ensure nursing facilities enroll in the MO HealthNet program. During the past three state fiscal years, over 90% of licensed nursing facilities in the state participated in the MO HealthNet program.



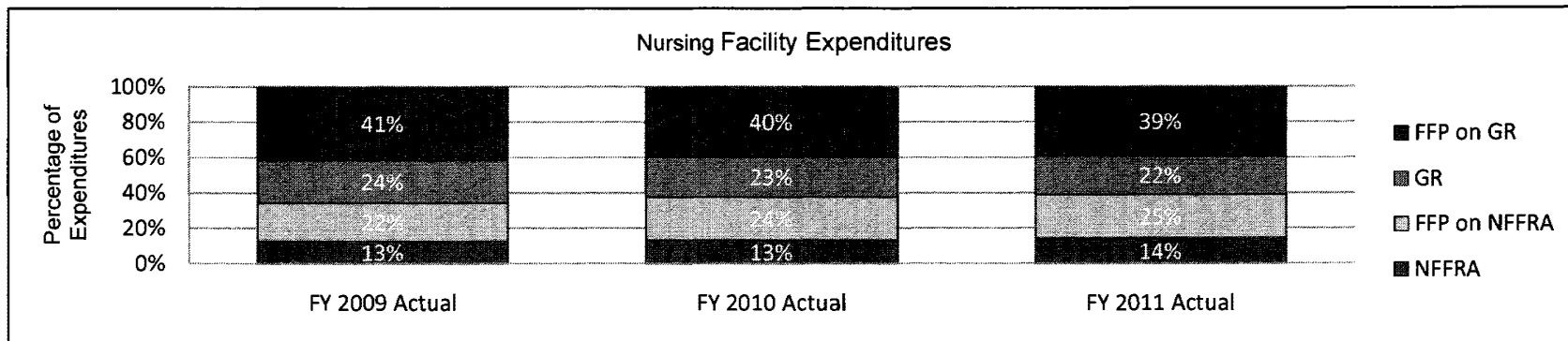


Effectiveness Measure 2: Provide adequate reimbursement to ensure MO HealthNet participants have sufficient access to care. In the past three state fiscal years, at least 26% of nursing facility beds were unoccupied. There are a sufficient number of beds available to care for MO HealthNet participants.



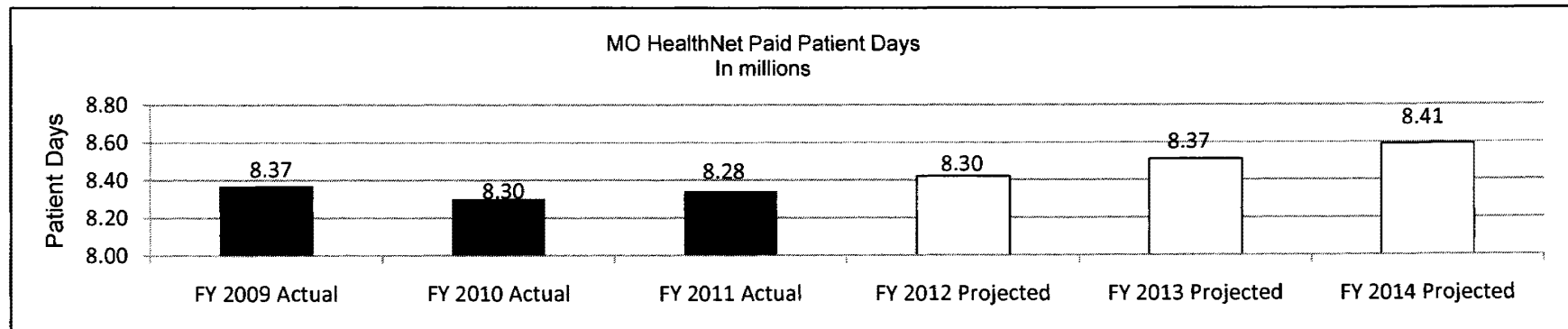
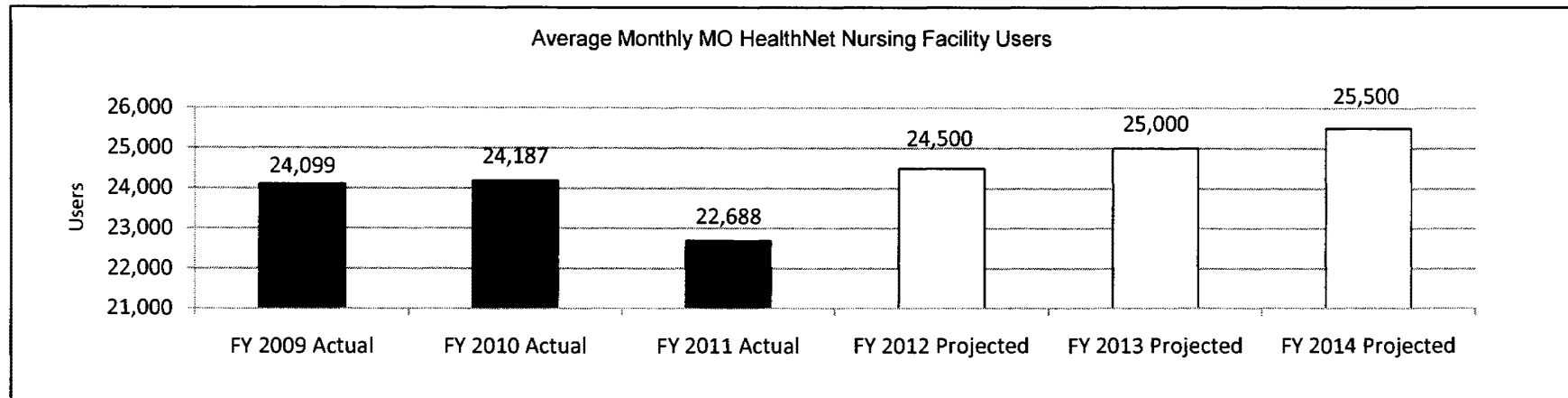
**7b. Provide an efficiency measure.**

Efficiency Measure 1: Provide funding for the nursing facility program. During the past three state fiscal years, the nursing facility provider tax and the federal matching funds on the assessment provided at least 35% of nursing facility expenditures. NFFRA allows the state to provide enhanced reimbursements to nursing facilities minimizing the need for general revenue.



**7c. Provide the number of clients/individuals served, if applicable.**

Nursing Facility Federal Reimbursement Allowance (NFFRA) payments are made on behalf of MO HealthNet eligibles for long-term care services.



**7d. Provide a customer satisfaction, if applicable.**

**NEW DECISION ITEM  
RANK: 21**

Department: Social Services  
Division: MO HealthNet  
DI Name: NFFRA Increase Authority

Budget Unit: 90567C  
DI#: 1886022

**1. AMOUNT OF REQUEST**

FY 2013 Budget Request			
GR	Federal	Other	Total
PS			
EE			
PSD		41,735,962	41,735,962
TRF			
Total		<b>41,735,962</b>	<b>41,735,962</b>
FTE			0.00

<b>Est. Fringe</b>	0	0	0	0
--------------------	---	---	---	---

Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds: Nursing Facility Federal Reimbursement Allowance Fund  
(NFFRA) (0196)

FY 2013 Governor's Recommendation			
GR	Federal	Other	Total
PS			
EE			
PSD			
TRF			
Total			
FTE			

<b>Est. Fringe</b>	0	0	0	0
--------------------	---	---	---	---

Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.

Other Funds:

**2. THIS REQUEST CAN BE CATEGORIZED AS:**

<input type="checkbox"/> New Legislation	<input type="checkbox"/> New Program	<input type="checkbox"/> Fund Switch
<input type="checkbox"/> Federal Mandate	<input type="checkbox"/> Program Expansion	<input type="checkbox"/> Cost to Continue
<input type="checkbox"/> GR Pick-Up	<input type="checkbox"/> Space Request	<input type="checkbox"/> Equipment Replacement
<input type="checkbox"/> Pay Plan	<input checked="" type="checkbox"/> Other: Increase Budget Authority	

**3. WHY IS THIS FUNDING NEEDED? PROVIDE AN EXPLANATION FOR ITEMS CHECKED IN #2. INCLUDE THE FEDERAL OR STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS PROGRAM.**

NDI SYNOPSIS: This item aligns NFFRA appropriation authority with anticipated payments.

This decision item provides increased appropriation authority to reflect planned FY 2013 nursing facility payments. Effective October 1, 2011, federal law increased the maximum provider assessment rate from 5.5% to 6%. MO HealthNet currently reimburses nursing facilities \$18 per day below their average cost. Using the increased assessment as state match, MHD is able to provide nursing facilities with a \$6 per day net increase.

State statute: RSMo. 198.401; Federal law: Social Security Action Section 1903(w); Federal Regulation: 42 CFR 443, Subpart B

**4. DESCRIBE THE DETAILED ASSUMPTIONS USED TO DERIVE THE SPECIFIC REQUESTED AMOUNT. (How did you determine that the requested number of FTE were appropriate? From what source or standard did you derive the requested levels of funding? Were alternatives such as outsourcing or automation considered? If based on new legislation, does request tie to TAFP fiscal note? If not, explain why. Detail which portions of the request are one-times and how those amounts were calculated.)**

The NFRA assessment is a required fee assessed to nursing facilities for the privilege of providing nursing facility services in Missouri. The assessment rate will increase from 5.5% to 5.95%.

	Total	GR	Federal	Other
Estimated Per Diem Payments less tax offsets	\$276,827,718			\$276,827,718
Core Appropriation Authority	\$235,091,756			\$235,091,756
Total	\$41,735,962			\$41,735,962

**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

Budget Object Class/Job Class	Dept Req GR DOLLARS	Dept Req GR FTE	Dept Req FED DOLLARS	Dept Req FED FTE	Dept Req OTHER DOLLARS	Dept Req OTHER FTE	Dept Req TOTAL DOLLARS	Dept Req TOTAL FTE	Dept Req One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions	0		0		41,735,962		41,735,962		
Total PSD	0		0		41,735,962		41,735,962		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	41,735,962	0.0	41,735,962	0.0	0

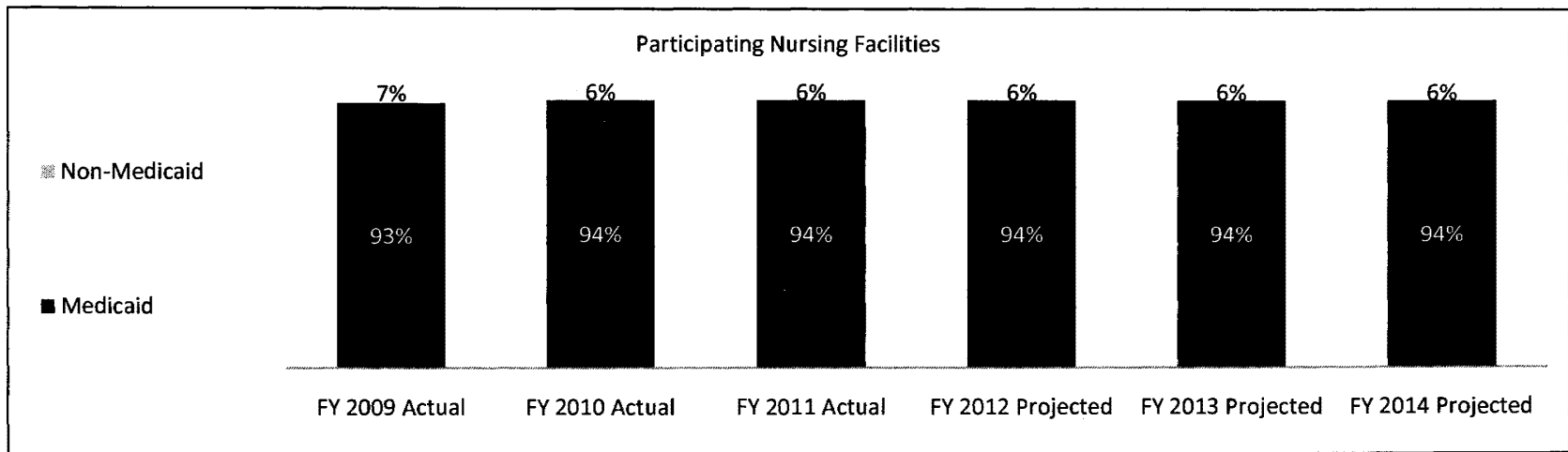
**5. BREAK DOWN THE REQUEST BY BUDGET OBJECT CLASS, JOB CLASS, AND FUND SOURCE. IDENTIFY ONE-TIME COSTS.**

Budget Object Class/Job Class	Gov Rec GR DOLLARS	Gov Rec GR FTE	Gov Rec FED DOLLARS	Gov Rec FED FTE	Gov Rec OTHER DOLLARS	Gov Rec OTHER FTE	Gov Rec TOTAL DOLLARS	Gov Rec TOTAL FTE	Gov Rec One-Time DOLLARS
Total PS	0	0.0	0	0.0	0	0.0	0	0.0	0
Total EE	0		0		0		0		0
Program Distributions									
Total PSD	0		0		0		0		0
Transfers									
Total TRF	0		0		0		0		0
Grand Total	0	0.0	0	0.0	0	0.0	0	0.0	0

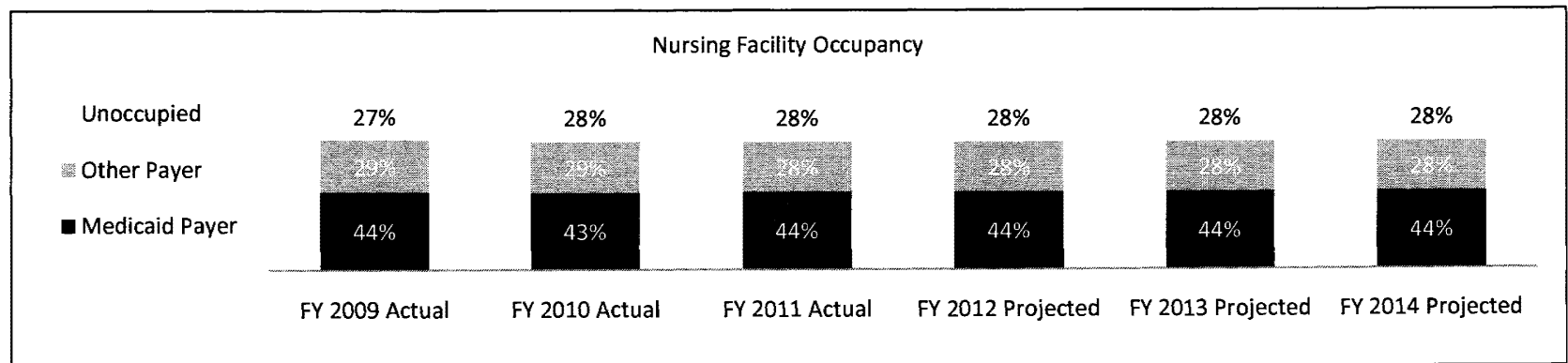
**6. PERFORMANCE MEASURES (If new decision item has an associated core, separately identify projected performance with & without additional funding.)**

**6a. Provide an effectiveness measure.**

Effectiveness Measure 1: Provide reimbursement that is sufficient to ensure nursing facilities enroll in the MO HealthNet program. During the past three state fiscal years, over 90% of licensed nursing facilities in the state participated in the MO HealthNet program.

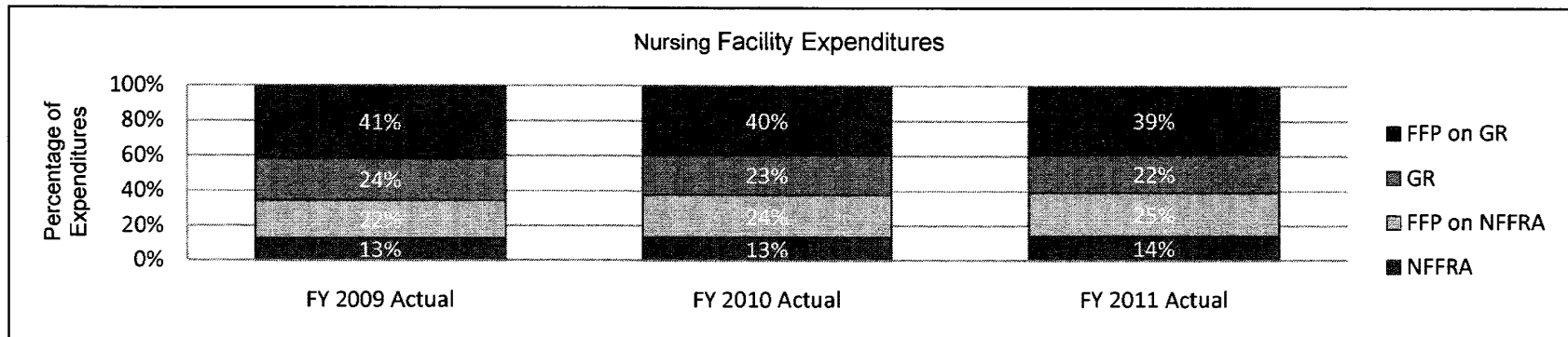


Effectiveness Measure 2: Provide adequate reimbursement to ensure MO HealthNet participants have sufficient access to care. In the past three state fiscal years, at least 27% of nursing facility beds were unoccupied.



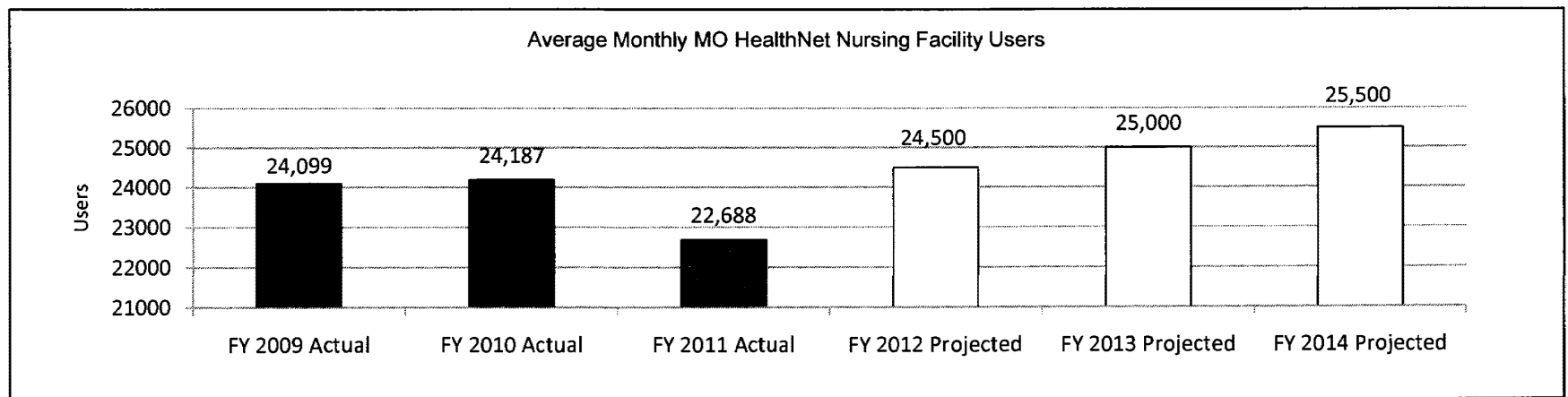
**6b. Provide an efficiency measure.**

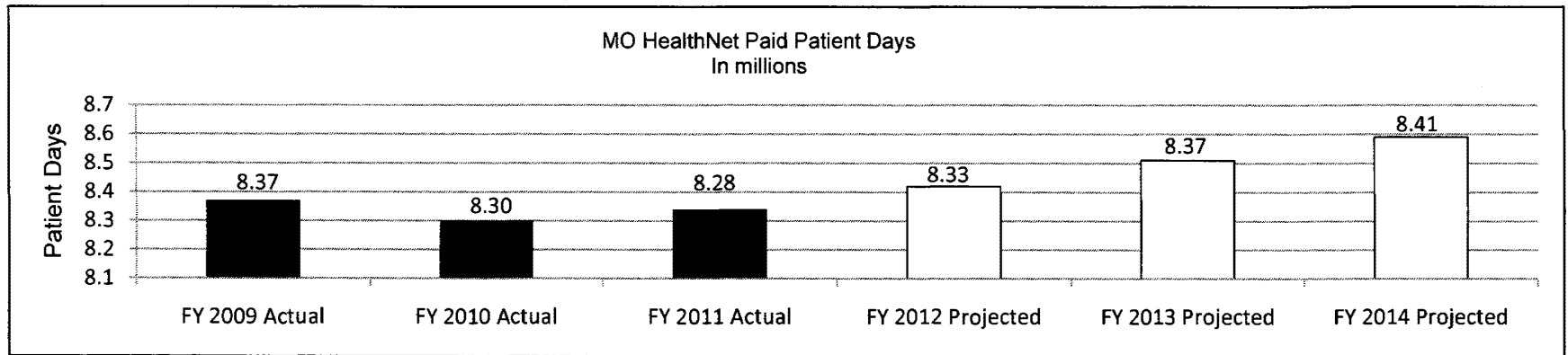
Efficiency Measure 1: Provide funding for the nursing facility program. During the past three state fiscal years, the nursing facility provider tax and the federal matching funds on the assessment provided at least 35% of nursing facility expenditures. NFFRA allows the state to provide enhanced reimbursements to nursing facilities minimizing the need for general revenue.



**6c. Provide the number of clients/individuals served, if applicable.**

Nursing Facility Federal Reimbursement Allowance (NFFRA) payments are made on behalf of MO HealthNet eligibles for long-term care services.





6d. Provide a customer satisfaction measure, if available.

**7. STRATEGIES TO ACHIEVE THE PERFORMANCE MEASUREMENT TARGETS:**



# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
NURSING FACILITY FED REIMB AL								
NFFRA Increase Authority - 1886022								
PROGRAM DISTRIBUTIONS	0	0.00	0	0.00	41,735,962	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	41,735,962	0.00	0	0.00
GRAND TOTAL	\$0	0.00	\$0	0.00	\$41,735,962	0.00	\$0	0.00
GENERAL REVENUE	\$0	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$41,735,962	0.00		0.00

# **School District Medicaid Claiming**

# FY13 Department of Social Services Report #9

# DECISION ITEM SUMMARY

Budget Unit									
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****	
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED	
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN	
SCHOOL DISTRICT CLAIMING									
CORE									
PROGRAM-SPECIFIC									
GENERAL REVENUE	69,954	0.00	69,954	0.00	69,954	0.00	0	0.00	
TITLE XIX-FEDERAL AND OTHER	29,174,659	0.00	54,653,770	0.00	54,653,770	0.00	0	0.00	
TOTAL - PD	29,244,613	0.00	54,723,724	0.00	54,723,724	0.00	0	0.00	
TOTAL	29,244,613	0.00	54,723,724	0.00	54,723,724	0.00	0	0.00	
GRAND TOTAL	\$29,244,613	0.00	\$54,723,724	0.00	\$54,723,724	0.00	\$0	0.00	

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: School District Medicaid Claiming

Budget Unit: 90569C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE				
PSD	69,954	54,653,770		54,723,724 E
TRF				
Total	69,954	54,653,770		54,723,724 E
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

Note: An "E" is requested for the \$54,653,770 Federal Fund authority.

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

## 2. CORE DESCRIPTION

This core request is for the ongoing funding for payments for school-based administrative and school-based EPSDT services.

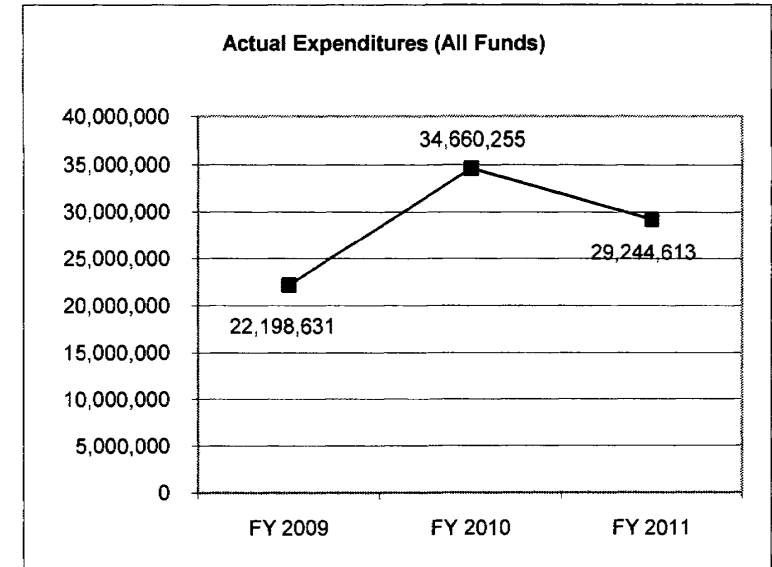
A goal of the MO HealthNet program is for each child to be healthy. The purpose of the services provided by the school is to ensure a comprehensive, preventative health care program for MO HealthNet eligible children. The program provides early and periodic (EPSDT) medical/dental screenings, diagnosis and treatment to correct or improve defects and chronic conditions found during the screenings.

## 3. PROGRAM LISTING (list programs included in this core funding)

School-based administrative and school-based EPSDT services.

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	33,369,908	35,924,908	33,369,908	54,723,724 E
Less Reverted (All Funds)	0	0	0	N/A
Budget Authority (All Funds)	33,369,908	35,924,908	33,369,908	N/A
Actual Expenditures (All Funds)	22,198,631	34,660,255	29,244,613	N/A
Unexpended (All Funds)	11,171,277	1,264,653	4,125,295	N/A
Unexpended, by Fund:				
General Revenue	0	0	0	N/A
Federal	11,171,277	1,264,653	4,125,295	N/A
Other	0	0	0	N/A
	(1)	(2)(3)	(4)	



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

Estimated "E" appropriations for Federal fund.

(1) Expenditures of \$20,803 were paid from the Supplemental Pool.

(2) Expenditures of \$22,707 were paid from the Supplemental Pool and \$3,064 from Physician Related appropriation.

(3) E increase of \$2,555,000.

(4) Expenditures of \$65,410 were paid from the Supplemental Pool.

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**CORE RECONCILIATION DETAIL**

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**DEPARTMENT OF SOCIAL SERVICES****SCHOOL DISTRICT CLAIMING**

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**5. CORE RECONCILIATION DETAIL**

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	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	PD	0.00	69,954	54,653,770	0	54,723,724	
	<b>Total</b>	<b>0.00</b>	<b>69,954</b>	<b>54,653,770</b>	<b>0</b>	<b>54,723,724</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	PD	0.00	69,954	54,653,770	0	54,723,724	
	<b>Total</b>	<b>0.00</b>	<b>69,954</b>	<b>54,653,770</b>	<b>0</b>	<b>54,723,724</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	PD	0.00	69,954	54,653,770	0	54,723,724	
	<b>Total</b>	<b>0.00</b>	<b>69,954</b>	<b>54,653,770</b>	<b>0</b>	<b>54,723,724</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
SCHOOL DISTRICT CLAIMING								
CORE								
PROGRAM DISTRIBUTIONS	29,244,613	0.00	54,723,724	0.00	54,723,724	0.00	0	0.00
TOTAL - PD	29,244,613	0.00	54,723,724	0.00	54,723,724	0.00	0	0.00
GRAND TOTAL	\$29,244,613	0.00	\$54,723,724	0.00	\$54,723,724	0.00	\$0	0.00
GENERAL REVENUE	\$69,954	0.00	\$69,954	0.00	\$69,954	0.00		0.00
FEDERAL FUNDS	\$29,174,659	0.00	\$54,653,770	0.00	\$54,653,770	0.00		0.00
OTHER FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: School Districts Medicaid Claiming**

**Program is found in the following core budget(s): School Districts Medicaid Claiming**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides funding for payments for school-based administrative claiming and school-based EPSDT services.*

This core appropriation provides funding for payment for school district administration claiming and school-based EPSDT services consisting of physical, occupational, and speech therapy services, audiology, personal care, private duty nursing, and psychology counseling services identified in an Individualized Education Plan (IEP) for school age children. An interagency agreement is in place between the MO HealthNet Division and participating school districts for administrative claiming. For school based direct services, each school district enrolls with MO HealthNet to provide the most efficient administration of the school-based EPSDT services for children within the school system. The provision of school-based EPSDT services by DESE school districts expands MO HealthNet EPSDT services and has been determined to be an effective method of coordinating services and improving care associated with providing identified services which are medically necessary and covered MO HealthNet services. The federal share of expenditures for these services provided by DESE school districts are being paid through this appropriation.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

The authority for this appropriation is the authority associated with the services reflected above.

### 3. Are there federal matching requirements? If yes, please explain.

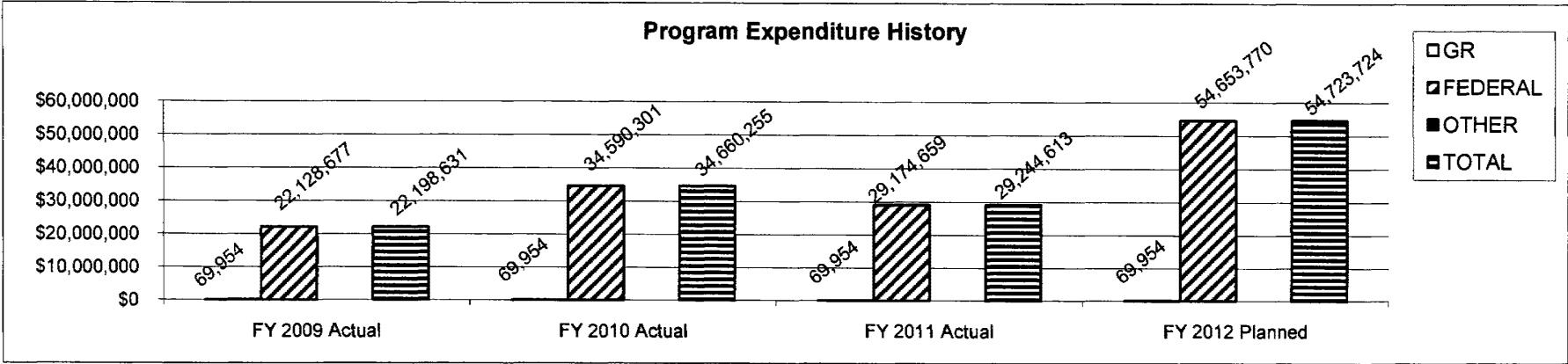
Medicaid allowable services provided by school districts receive a federal medical assistance percentage (FMAP) on expenditures. Administrative expenditures earn a 50% federal match and the state matching requirement is 50%. Direct services earn a higher federal participation rate. Generally, Missouri's FMAP for FY 12 is a blended 63.41% federal match rate. The state matching requirement is 36.59%.

### 4. Is this a federally mandated program? If yes, please explain.

No



**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**

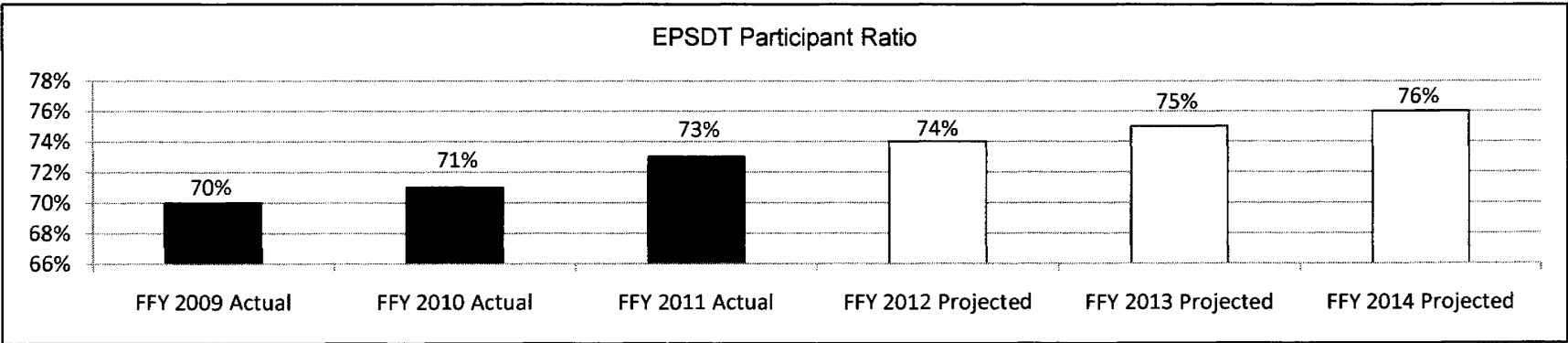


**6. What are the sources of the "Other " funds?**

N/A

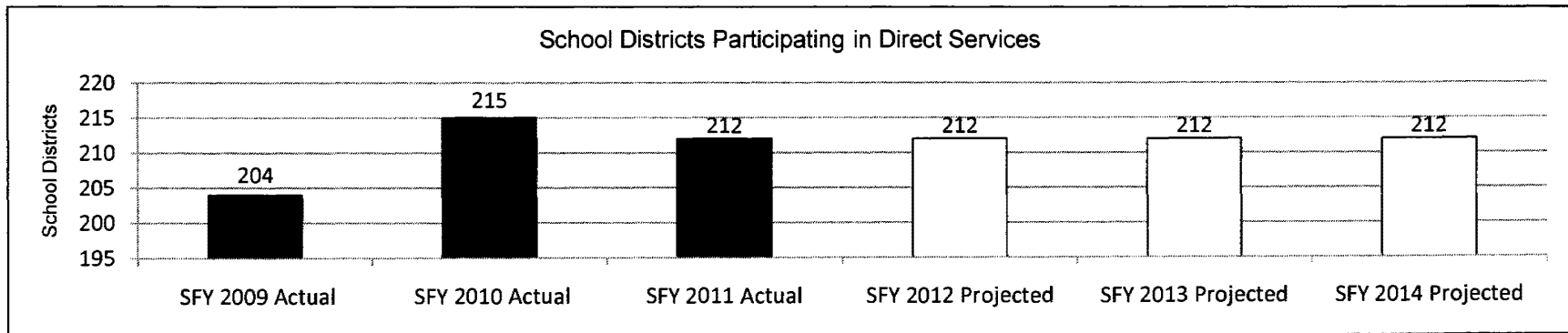
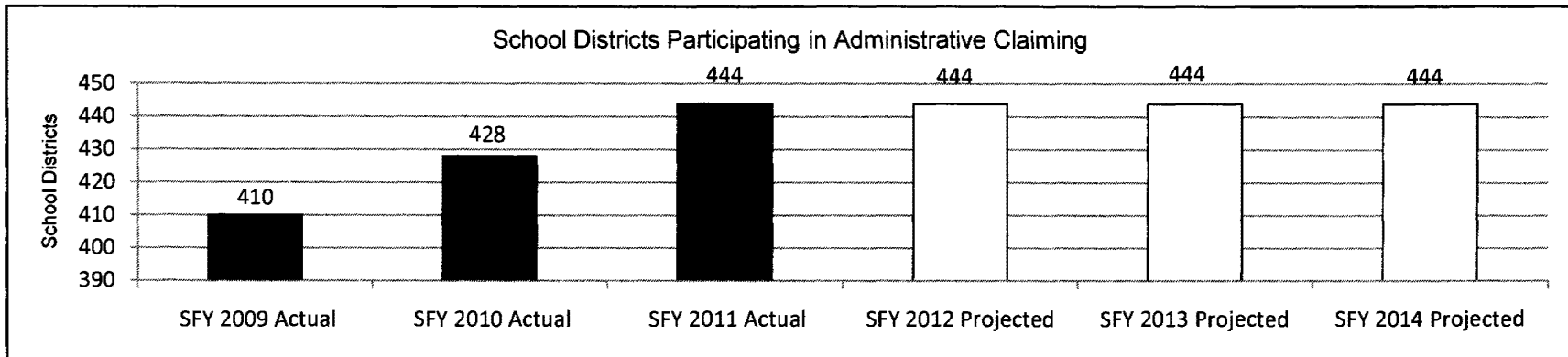
**7a. Provide an effectiveness measure.**

Effectiveness Measure 1: Increase the provision of medically necessary services to MO HealthNet eligible children as provided through EPSDT by 42 CFR 441 Subpart B. The EPSDT participant ratio increased by 2% in the past federal fiscal year. The rate for FFY11 is 73%.



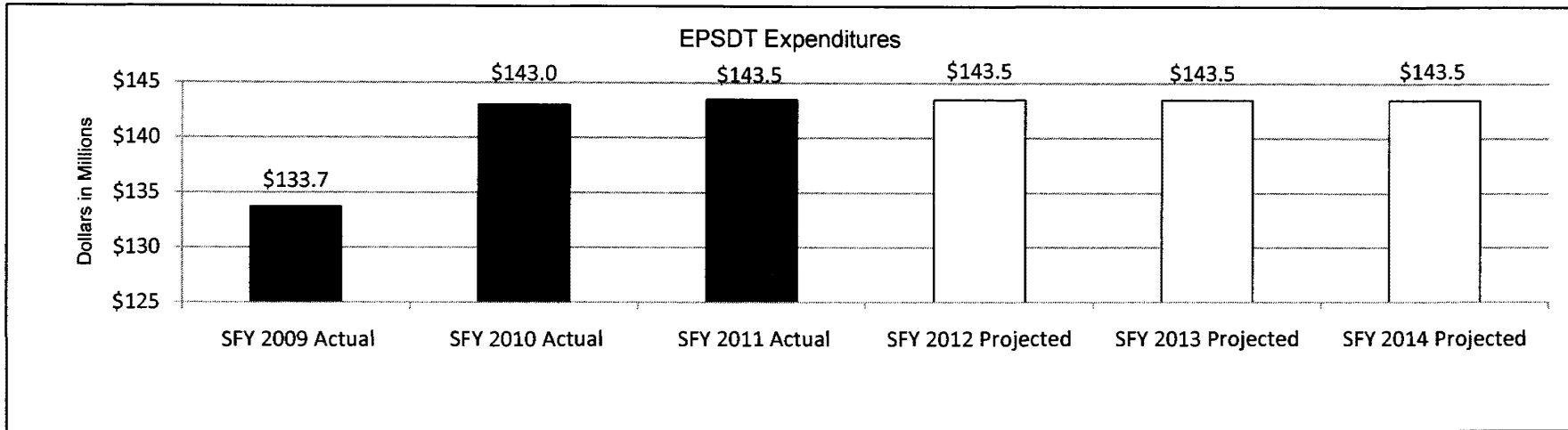
Based on prior federal fiscal year as reported to CMS.

Effectiveness Measure 2: Increase the number of schools participating in administrative claiming and school based services. In SFY 2011 there were 444 schools participating in administrative claiming which is an increase of 16 schools. In SFY 2011, there were 212 school districts participating in school based services which is an decrease of 3 schools. Any school district in the state may participate.

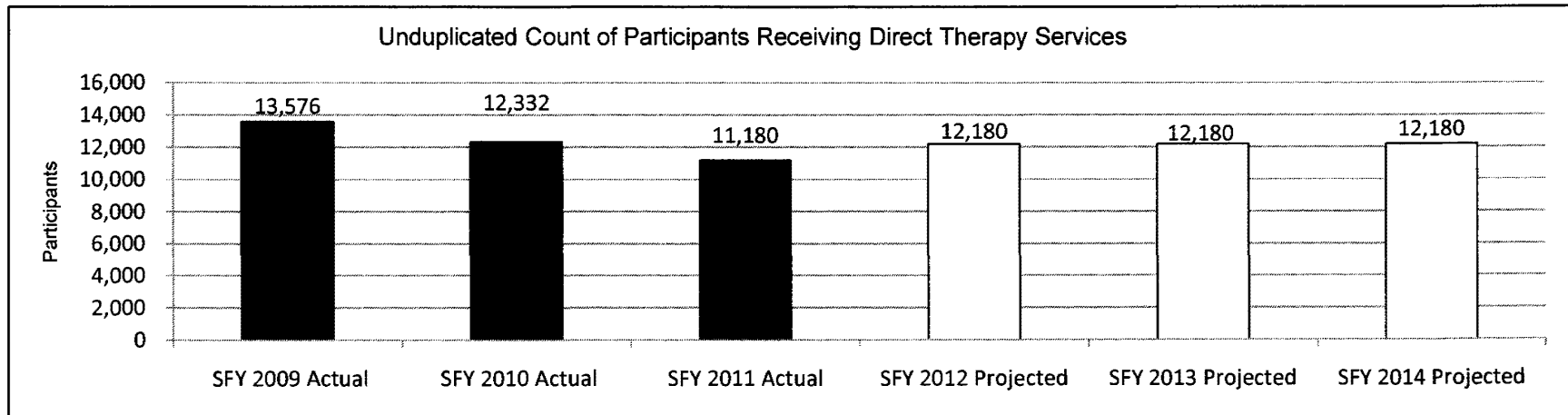


**7b. Provide an efficiency measure.**

Efficiency Measure: Increase the EPSDT participant ratio while maximizing federal claiming opportunities to benefit local school districts. In SFY 2011, EPSDT expenditures increased approximately .3% from SFY 2010 while the EPSDT participant ratio increased 2% in FFY 2011. SFY11 EPSDT expenditures are \$143.5 million.



**7c. Provide the number of clients/individuals served, if applicable.**



**7d. Provide a customer satisfaction measure, if available.**

**State Medical**

# FY13 Department of Social Services Report #9

## DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
<b>STATE MEDICAL</b>								
<b>CORE</b>								
<b>EXPENSE &amp; EQUIPMENT</b>								
GENERAL REVENUE	143,244	0.00	176,250	0.00	176,250	0.00	0	0.00
TOTAL - EE	143,244	0.00	176,250	0.00	176,250	0.00	0	0.00
<b>PROGRAM-SPECIFIC</b>								
GENERAL REVENUE	29,450,451	0.00	31,801,623	0.00	31,801,623	0.00	0	0.00
PHARMACY REIMBURSEMENT ALLOWAN	1,188,686	0.00	1,460,328	0.00	1,460,328	0.00	0	0.00
HEALTH INITIATIVES	342,834	0.00	353,437	0.00	353,437	0.00	0	0.00
TOTAL - PD	30,981,971	0.00	33,615,388	0.00	33,615,388	0.00	0	0.00
<b>TOTAL</b>	<b>31,125,215</b>	<b>0.00</b>	<b>33,791,638</b>	<b>0.00</b>	<b>33,791,638</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>Pharmacy PMPM Increase - 1886014</b>								
<b>PROGRAM-SPECIFIC</b>								
GENERAL REVENUE	0	0.00	0	0.00	433,442	0.00	0	0.00
TOTAL - PD	0	0.00	0	0.00	433,442	0.00	0	0.00
<b>TOTAL</b>	<b>0</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>	<b>433,442</b>	<b>0.00</b>	<b>0</b>	<b>0.00</b>
<b>GRAND TOTAL</b>	<b>\$31,125,215</b>	<b>0.00</b>	<b>\$33,791,638</b>	<b>0.00</b>	<b>\$34,225,080</b>	<b>0.00</b>	<b>\$0</b>	<b>0.00</b>

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# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: State Medical

Budget Unit: 90585C

## 1. CORE FINANCIAL SUMMARY

FY 2013 Budget Request				
	GR	Federal	Other	Total
PS				
EE	176,250			176,250
PSD	31,801,623		1,813,765	33,615,388
TRF				
Total	31,977,873		1,813,765	33,791,638
FTE				0.00

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds: Health Initiatives Fund (HIF) (0275)  
Pharmacy Reimbursement Allowance Fund (0144)

FY 2013 Governor's Recommendation				
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

Est. Fringe	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

## 2. CORE DESCRIPTION

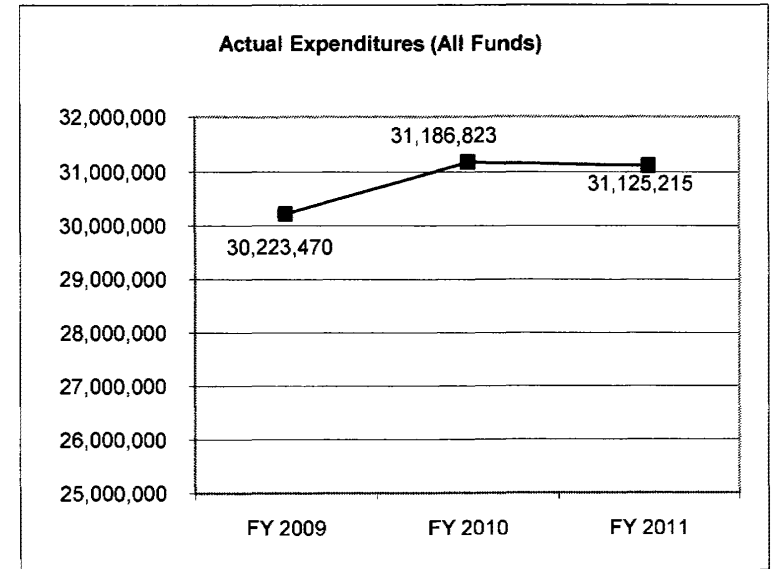
This core request is for the continued funding of the fee-for-service programs for the State Medical participants. Funding is necessary to provide health care services to this population. In addition, this core is used to reimburse providers for mandatory child death autopsies. Autopsy reimbursement is a key component of Child Fatality Review Program (CFRP). This core will also be used to pay for court ordered tuberculosis testing as needed.

## 3. PROGRAM LISTING (list programs included in this core funding)

State Medical Services

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Current Yr.
Appropriation (All Funds)	30,234,821	31,197,426	33,054,871	33,791,638
Less Reverted (All Funds)	(10,603)	(10,603)	(10,603)	N/A
Budget Authority (All Funds)	30,224,218	31,186,823	33,044,268	N/A
Actual Expenditures (All Funds)	30,223,470	31,186,823	31,125,215	N/A
Unexpended (All Funds)	748	0	1,919,053	N/A
Unexpended, by Fund:				
General Revenue	748	0	1,647,411	N/A
Federal	0	0	0	N/A
Other	0	0	271,642	N/A
	(1)	(2)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary expenditure restrictions.

#### NOTES:

(1) Expenditures of \$358,091 were paid from the Supplemental Pool.

(2) Expenditures of \$1,294,781 were paid from the Supplemental Pool.

**CORE RECONCILIATION DETAIL**

**DEPARTMENT OF SOCIAL SERVICES**

**STATE MEDICAL**

**5. CORE RECONCILIATION DETAIL**

	<b>Budget Class</b>	<b>FTE</b>	<b>GR</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>	<b>Explanation</b>
<b>TAFP AFTER VETOES</b>							
	EE	0.00	176,250	0	0	176,250	
	PD	0.00	31,801,623	0	1,813,765	33,615,388	
	<b>Total</b>	<b>0.00</b>	<b>31,977,873</b>	<b>0</b>	<b>1,813,765</b>	<b>33,791,638</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	EE	0.00	176,250	0	0	176,250	
	PD	0.00	31,801,623	0	1,813,765	33,615,388	
	<b>Total</b>	<b>0.00</b>	<b>31,977,873</b>	<b>0</b>	<b>1,813,765</b>	<b>33,791,638</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	EE	0.00	176,250	0	0	176,250	
	PD	0.00	31,801,623	0	1,813,765	33,615,388	
	<b>Total</b>	<b>0.00</b>	<b>31,977,873</b>	<b>0</b>	<b>1,813,765</b>	<b>33,791,638</b>	



# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
STATE MEDICAL								
CORE								
PROFESSIONAL SERVICES	143,244	0.00	176,250	0.00	176,250	0.00	0	0.00
TOTAL - EE	143,244	0.00	176,250	0.00	176,250	0.00	0	0.00
PROGRAM DISTRIBUTIONS	30,981,971	0.00	33,615,388	0.00	33,615,388	0.00	0	0.00
TOTAL - PD	30,981,971	0.00	33,615,388	0.00	33,615,388	0.00	0	0.00
GRAND TOTAL	\$31,125,215	0.00	\$33,791,638	0.00	\$33,791,638	0.00	\$0	0.00
GENERAL REVENUE	\$29,593,695	0.00	\$31,977,873	0.00	\$31,977,873	0.00		0.00
FEDERAL FUNDS	\$0	0.00	\$0	0.00	\$0	0.00		0.00
OTHER FUNDS	\$1,531,520	0.00	\$1,813,765	0.00	\$1,813,765	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: State Medical**

**Program is found in the following core budget(s): State Medical**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides payment for services for State Medical participants. State Medical participants are individuals who do not meet categorical eligibility criteria for Title XIX.*

The State Medical program, funded solely by state funds, provides health care services for individuals who do not meet categorical eligibility criteria for Title XIX. State Medical participants are in one of four categories of eligibility: Child Welfare Services (CWS); Blind Pension (BP); Presumptive Eligibility for Pregnant Women; or medical care for youth in the custody of the Division of Youth Services (DYS-GR). The unique aspect of the State Medical appropriation is that payments are made for certain eligibility groups only, but for nearly all the same services which are reimbursed for Title XIX eligibles.

All Medical Assistance programs which are available through the Title XIX program are also available through the State Medical program with the exception of the following: Buy-In, HIPP, transplant and NEMT.

Child Welfare Services (CWS) - These eligibles are children who are in the legal care and custody of the Children's Division and have been placed in foster care, but are not eligible for MAF - Foster Care MO HealthNet payments (not eligible for federal Title IV-E through the Children's Division). These children are identified as Homeless, Dependent, and Neglected (HDN), but due to income standards are not eligible for federal Title XIX medical assistance.

Blind Pension (BP) - The Blind Pension program was established in 1921 and is financed entirely by state funds. This program provides assistance for blind persons who do not qualify under the supplemental aid to the blind law and who are not eligible for Supplemental Security Income (SSI) benefits. Each participant receives a monthly cash grant (Family Support Division appropriation) and State Medical assistance. In order to qualify for the BP program, a person must meet all of the following eligibility requirements: 18 years of age or older; living in the state; has not given away, sold or transferred real or personal property worth more than \$20,000; is of good moral character; has no sighted spouse living in Missouri who can provide support; does not publicly solicit alms; is determined blind as defined by RSMo. 290.040; is found to be ineligible for Supplemental Aid to the Blind; is willing to have medical treatment or an operation to cure blindness (unless he/she is 75 years of age or older); is not a resident of a public, private, or endowed institution except a public medical institution; and is found ineligible to receive federal Supplemental Security Income (SSI) benefits.

Presumptive Eligibility for Pregnant Women - This is a temporary eligibility program that covers services provided to pregnant women while they wait for formal determination of MO HealthNet eligibility. The participant is State Medical eligible from the time of eligibility rejection to the end of the temporary eligibility period. These participants may receive ambulatory prenatal care to include the following services: physician/clinic, nurse midwife, diagnostic lab and x-ray, pharmacy, and outpatient hospital services.

Division of Youth Services - General Revenue (DYS-GR) - This program covers youth in the legal custody of the Division of Youth Services (DYS) who reside in facilities of 25 beds or more (and thus cannot qualify for MO HealthNet coverage since they reside in an institutional setting). Every youth that is committed to DHS is originally set up in this category for medical coverage. When the residential setting is determined, if the commitment is to a facility of 25 beds or more, then the child remains eligible for DHS-GR. Otherwise, eligibility is established for Title XIX Medicaid for those children committed to facilities with less than 25 beds. Children placed in a not-for-profit residential group facility (RGF) by a juvenile court are MO HealthNet eligible during their term of placement. Children who are placed in such homes by their parent(s), and who are already eligible for MO HealthNet coverage, will continue to receive MO HealthNet benefits while in the group facility .

**2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)**

State statute: RSMo. 208.151, 208.152, 191.831

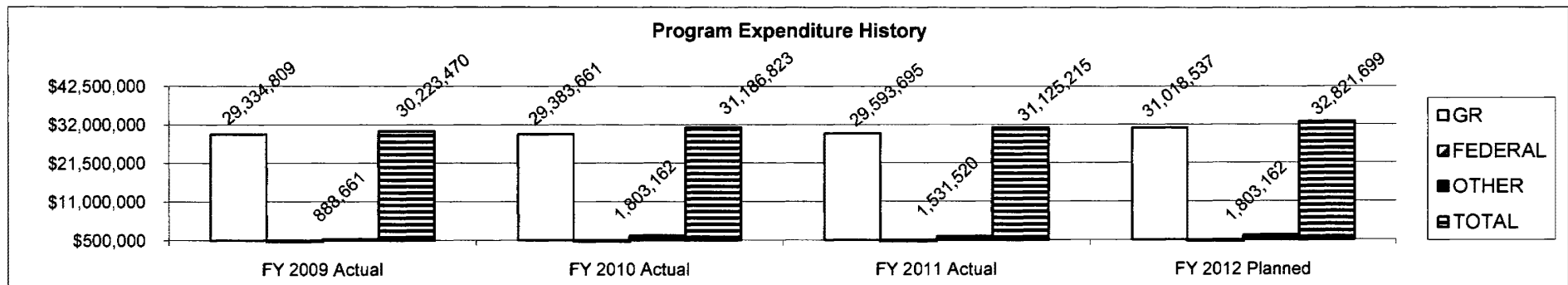
**3. Are there federal matching requirements? If yes, please explain.**

No.

**4. Is this a federally mandated program? If yes, please explain.**

No.

**5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.**



Reverted: \$959,336 General Revenue; \$10,603 Other Funds

**6. What are the sources of the "Other " funds?**

Health Initiatives Fund (0275) and Pharmacy Federal Reimbursement Allowance Fund (0144).

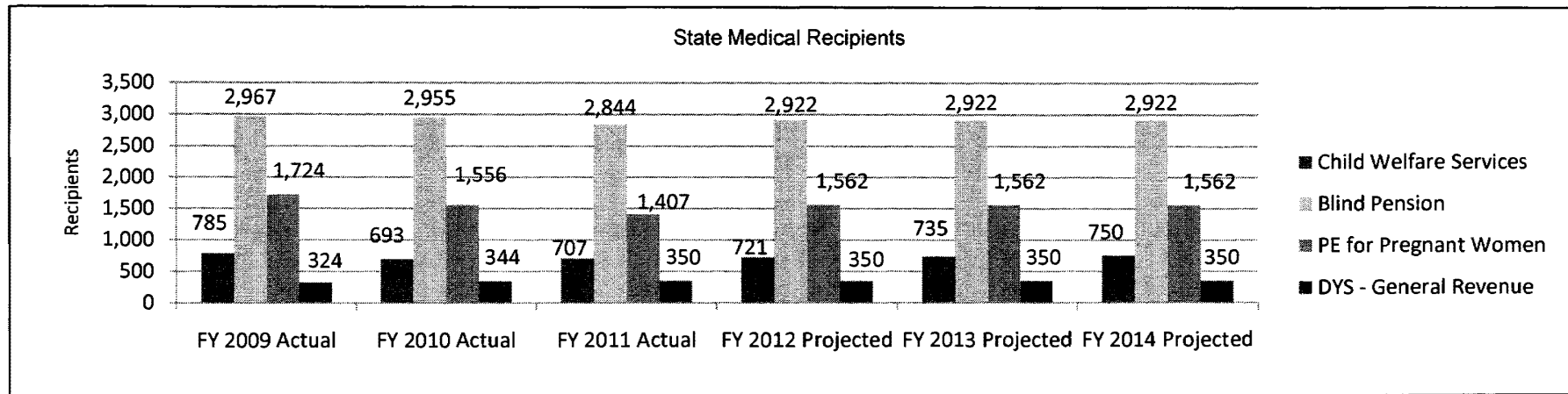
**7a. Provide an effectiveness measure.**

This appropriation represents a group of eligibles and not just one program. Effectiveness measures for the State Medical appropriation are incorporated into fee-for-service program sections.

**7b. Provide an efficiency measure.**

This appropriation represents a group of eligibles and not just one program. Efficiency measures for the State Medical appropriation are incorporated into fee-for-service program sections.

**7c. Provide the number of clients/individuals served, if applicable.**



**7d. Provide a customer satisfaction measure, if available.**

# **MO HealthNet Supplemental Pool**

# FY13 Department of Social Services Report #9

# DECISION ITEM SUMMARY

Budget Unit								
Decision Item	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Budget Object Summary	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Fund	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
MO HLTHNET SUPP POOL								
CORE								
EXPENSE & EQUIPMENT								
TITLE XIX-FEDERAL AND OTHER	0	0.00	1,555,525	0.00	1,555,525	0.00	0	0.00
THIRD PARTY LIABILITY COLLECT	0	0.00	1,292,625	0.00	1,292,625	0.00	0	0.00
TOTAL - EE	0	0.00	2,848,150	0.00	2,848,150	0.00	0	0.00
PROGRAM-SPECIFIC								
GENERAL REVENUE	18,846,462	0.00	0	0.00	0	0.00	0	0.00
TITLE XIX-FEDERAL AND OTHER	17,293,781	0.00	22,551,961	0.00	22,551,961	0.00	0	0.00
UNCOMPENSATED CARE FUND	0	0.00	1	0.00	1	0.00	0	0.00
THIRD PARTY LIABILITY COLLECT	7,571,156	0.00	6,278,531	0.00	6,278,531	0.00	0	0.00
FEDERAL REIMBURSEMENT ALLOWANCE	0	0.00	1	0.00	1	0.00	0	0.00
NURSING FACILITY FED REIM ALLW	0	0.00	181,500	0.00	181,500	0.00	0	0.00
HEALTH INITIATIVES	9,900,000	0.00	0	0.00	0	0.00	0	0.00
PREMIUM	3,837,940	0.00	3,837,940	0.00	3,837,940	0.00	0	0.00
RECOVERY AUDIT AND COMPLIANCE	0	0.00	1	0.00	1	0.00	0	0.00
TOTAL - PD	57,449,339	0.00	32,849,935	0.00	32,849,935	0.00	0	0.00
TOTAL	57,449,339	0.00	35,698,085	0.00	35,698,085	0.00	0	0.00
GRAND TOTAL	\$57,449,339	0.00	\$35,698,085	0.00	\$35,698,085	0.00	\$0	0.00

# CORE DECISION ITEM

Department: Social Services  
Division: MO HealthNet  
Core: MO HealthNet Supplemental Pool

Budget Unit: 90582C

## 1. CORE FINANCIAL SUMMARY

	FY 2013 Budget Request			
	GR	Federal	Other	Total
PS				
EE		1,555,525	1,292,625	2,848,150
PSD		22,551,961	10,297,974	32,849,935
TRF				
Total		24,107,486	11,590,599	35,698,085
FTE			0.00	

<b>Est. Fringe</b>	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds: Premium Fund (0885)  
Third Party Liability Collections (TPL) (0120)  
Uncompensated Care Fund (UCF) (0108)  
Federal Reimbursement Allowance (FRA) Fund (0142)  
Nursing Facility Federal Reimbursement Allowance (NFRA) (0196)  
Recovery Audit and Compliance Fund (0974)

Note: An "E" is requested for the \$1 Recovery Audit and Compliance Fund.

	FY 201 Governor's Recommendation			
	GR	Federal	Other	Total
PS				
EE				
PSD				
TRF				
Total				
FTE				

<b>Est. Fringe</b>	0	0	0	0
Note: Fringes budgeted in House Bill 5 except for certain fringes budgeted directly to MoDOT, Highway Patrol, and Conservation.				

Other Funds:

## 2. CORE DESCRIPTION

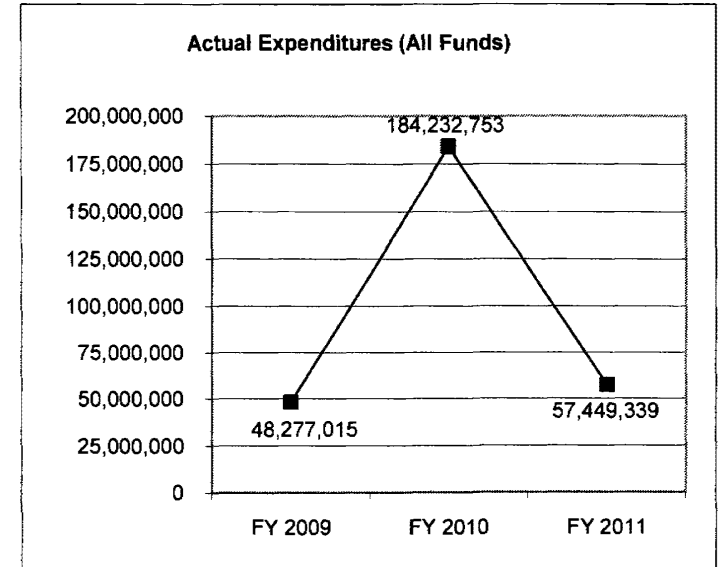
This core request is for the continued funding of the Mo HealthNet Supplemental Pool. The Supplemental Pool is needed to enable the division to respond to unanticipated changes in the cost of providing health care to MO HealthNet participants.

## 3. PROGRAM LISTING (list programs included in this core funding)

Supports MO HealthNet Program

#### 4. FINANCIAL HISTORY

	FY 2009 Actual	FY 2010 Actual	FY 2011 Current Yr.	FY 2012 Current Yr.	
Appropriation (All Funds)	55,684,691	236,371,043	156,102,833	35,698,085	E
Less Reverted (All Funds)	(1)	0	0	N/A	
Budget Authority (All Funds)	55,684,690	236,371,043	156,102,833	N/A	
Actual Expenditures (All Funds)	48,277,015	184,232,753	57,449,339	N/A	
Unexpended (All Funds)	7,407,675	52,138,290	98,653,494	N/A	
Unexpended, by Fund:					
General Revenue	0	0	28,512,775	N/A	
Federal	2,930,228	48,496,356	69,959,217	N/A	
Other	4,477,447	3,641,934	181,502	N/A	
	(1)	(2)	(3)		



Reverted includes Governor's standard 3 percent reserve (when applicable) and any extraordinary withholdings.

#### NOTES:

An "E" is requested for \$1 Recovery Audit and Compliance Fund.

(1) Supplemental appropriation authority increase: Federal \$11,668,707 and Uncompensated Care Fund \$8,317,899.  
(Lapsed \$2,930,352 in Federal and \$2,742,563 in Uncompensated Care.)

(2) Supplemental appropriation authority increase: Federal \$107,782,467; Federal Budget Stabilization \$77,490,492; Uncompensated Care Fund \$700,000; Pharmacy Rebates \$5,700,000 and Life Science Research Funds \$9,000,000.  
(Lapsed \$39,237,171 in Federal, \$9,259,280 in Federal Budget Stabilization, \$2,917,873 in Pharmacy Rebates, \$181,500 in NFFRA and \$528,093 in Premiums.)

(3) Supplemental appropriation authority increase: General Revenue \$47,359,237; Federal \$63,145,512; Health Initiatives Fund \$9,900,000.  
(Lapsed \$28,512,775 in General Revenue, \$69,959,217 in Federal and \$181,500 in NFFRA.)



#### 4. FINANCIAL HISTORY

##### Supplemental Pool Payments By Services

	FY 2009	FY 2010	FY 2011
Pharmacy	\$0	\$10,759,974	\$27,365,119
Physician Related Services	\$22,501,730	\$89,692,366	\$0
Medicals	\$454,433	\$2,846,935	\$0
Dental	\$1,902,556	\$2,523,921	\$0
Premium Payments	\$3,578,354	\$7,214,660	\$0
Home Health	\$0	\$81,493	\$115,201
PACE	\$0	\$0	\$194,408
Rehab & Specialty Services	\$3,283,111	\$15,916,437	\$461,393
NEMT	\$0	\$0	\$122,694
Hospital Care	\$6,130,134	\$32,443,758	\$21,899,226
Managed Care	\$0	\$17,865,128	\$4,718,851
Women's Health (1115 Waiver)	\$0	\$102,666	\$569,812
CHIP	\$0	\$0	\$1,937,225
DESE Services	\$20,803	\$22,707	\$65,410
State Medical	\$358,091	\$1,294,780	\$0
In-Home Care (DHSS)	\$5,384,946	\$2,683,370	\$0
Other Misc	\$205	\$619,127	\$0
Residential Treatment Service	\$4,662,652	\$165,251	\$0
Total	\$48,277,015	\$184,232,573	\$57,449,339

**CORE RECONCILIATION DETAIL**

**DEPARTMENT OF SOCIAL SERVICES**  
**MO HLTHNET SUPP POOL**

**5. CORE RECONCILIATION DETAIL**

	Budget Class	FTE	GR	Federal	Other	Total	Explanation
<b>TAFP AFTER VETOES</b>							
	EE	0.00	0	1,555,525	1,292,625	2,848,150	
	PD	0.00	0	22,551,961	10,297,974	32,849,935	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>24,107,486</b>	<b>11,590,599</b>	<b>35,698,085</b>	
<b>DEPARTMENT CORE REQUEST</b>							
	EE	0.00	0	1,555,525	1,292,625	2,848,150	
	PD	0.00	0	22,551,961	10,297,974	32,849,935	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>24,107,486</b>	<b>11,590,599</b>	<b>35,698,085</b>	
<b>GOVERNOR'S RECOMMENDED CORE</b>							
	EE	0.00	0	1,555,525	1,292,625	2,848,150	
	PD	0.00	0	22,551,961	10,297,974	32,849,935	
	<b>Total</b>	<b>0.00</b>	<b>0</b>	<b>24,107,486</b>	<b>11,590,599</b>	<b>35,698,085</b>	

# FY13 Department of Social Services Report #10

## DECISION ITEM DETAIL

Budget Unit	FY 2011	FY 2011	FY 2012	FY 2012	FY 2013	FY 2013	*****	*****
Decision Item	ACTUAL	ACTUAL	BUDGET	BUDGET	DEPT REQ	DEPT REQ	SECURED	SECURED
Budget Object Class	DOLLAR	FTE	DOLLAR	FTE	DOLLAR	FTE	COLUMN	COLUMN
MO HLTHNET SUPP POOL								
CORE								
PROFESSIONAL SERVICES	0	0.00	2,848,150	0.00	2,848,150	0.00	0	0.00
TOTAL - EE	0	0.00	2,848,150	0.00	2,848,150	0.00	0	0.00
PROGRAM DISTRIBUTIONS	57,449,339	0.00	32,849,935	0.00	32,849,935	0.00	0	0.00
TOTAL - PD	57,449,339	0.00	32,849,935	0.00	32,849,935	0.00	0	0.00
GRAND TOTAL	\$57,449,339	0.00	\$35,698,085	0.00	\$35,698,085	0.00	\$0	0.00
GENERAL REVENUE	\$18,846,462	0.00	\$0	0.00	\$0	0.00		0.00
FEDERAL FUNDS	\$17,293,781	0.00	\$24,107,486	0.00	\$24,107,486	0.00		0.00
OTHER FUNDS	\$21,309,096	0.00	\$11,590,599	0.00	\$11,590,599	0.00		0.00

## PROGRAM DESCRIPTION

**Department: Social Services**

**Program Name: MO HealthNet Supplemental Pool**

**Program is found in the following core budget(s): MO HealthNet Supplemental Pool**

### 1. What does this program do?

*PROGRAM SYNOPSIS: Provides funding for the division to respond to unanticipated changes in the cost of providing health care to MO HealthNet participants.*

The MO HealthNet Supplemental Pool Section was the result of rapidly expanding MO HealthNet participants and unpredictability of resulting costs. Substantial supplemental budget requests in successive years prompted the Missouri state legislature to appropriate funding for unanticipated MO HealthNet expenditures. Typically, the supplemental pool has been utilized by the legislature to appropriate funding under certain unique circumstances. These include funding for major one-time program expenditures, such as residual claims, and funding to be made available for unanticipated fee-for-service and/or managed care expenditures.

### 2. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

The legal authority for the Supplemental Pool is the authority associated with each MO HealthNet program. See each program description for the specific federal and state authority.

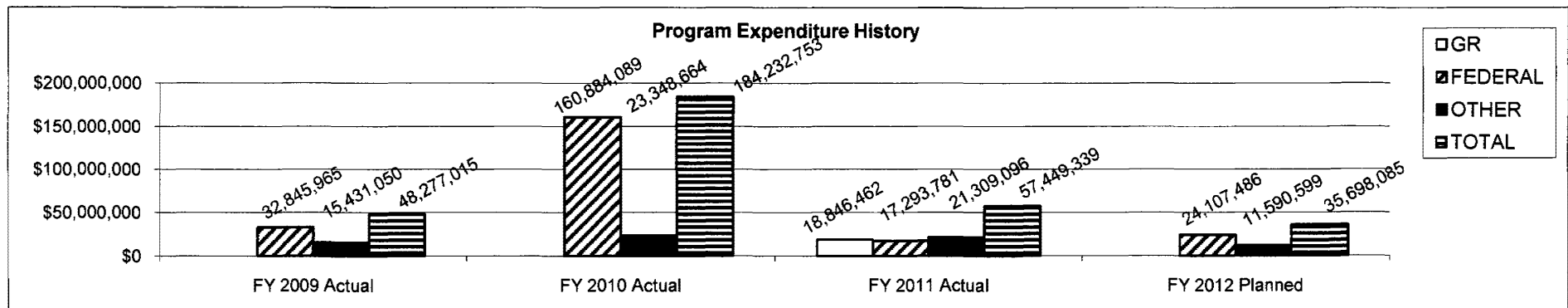
### 3. Are there federal matching requirements? If yes, please explain.

The federal matching requirements for the MO HealthNet Supplemental Pool are the requirements associated with any of the MO HealthNet programs paid from the supplemental pool. See each program description for specific federal matching requirements.

### 4. Is this a federally mandated program? If yes, please explain.

The MO HealthNet Supplemental Pool supports both mandated and non-mandated programs. See each program description for specifics.

### 5. Provide actual expenditures for the prior three fiscal years and planned expenditures for the current fiscal year.



**6. What are the sources of the "Other " funds?**

Third Party Liability Collections Fund (0120), Premium Fund (0885), Nursing Facility Federal Reimbursement Allowance Fund (0196), Uncompensated Care Fund (0108), Federal Reimbursement Allowance Fund (0142) and Recovery Audit and Compliance Fund (0974).

**7a. Provide an effectiveness measure.**

This appropriation represents a group of eligibles and not one program. Effectiveness measures affecting the MO HealthNet Supplemental Pool appropriation are incorporated into fee-for-service program sections.

**7b. Provide an efficiency measure.**

This appropriation represents a group of eligibles and not one program. Efficiency measures affecting the MO HealthNet Supplemental Pool appropriation are incorporated into fee-for-service program sections.

**7c. Provide the number of clients/individuals served, if applicable.**

Supplemental Pool Expenditures		
SFY	Actual	Projected
2009	\$48.3 mil	\$35.7 mil
2010	\$184.2 mil	\$35.7 mil
2011	\$62.5 mil	\$35.7 mil
2012		\$35.7 mil
2013		\$35.7 mil
2014		\$35.7 mil

**7d. Provide a customer satisfaction measure, if available.**